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ORIGINAL LECTURES.

AN ADDRESS ON ABDOMINAL SURGERY.

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MR. PRESIDENT AND GENTLEMEN: Every gardener knows that a plant long grown on the same soil rises or sinks, or somehow or other gets to a level from which it varies not so long as its conditions remain the same; and he knows as well, that if he takes that plant to a new soil which suits it, if he grows it under new conditions, its growth and change and development are practically endless. What we know of plants is, within limits, true of humanity, and if we require proof and illustration of this where need we go but to this endless continent of yours?

I am not at present concerned with natural boundaries created by languages which come from Sweden and Poland, Denmark and Scotland, Russia and Ireland, which temporarily limit intercourse between different peoples who perhaps settled here. Still less do I trouble about a line on the map which marks a practical republic on the south from a splendid democracy on the north. I have only to do with the great fact in human history—I think the greatest fact—that from out of the troubles and distresses of our eastern countries, or out of the countries oppressed by over-population, and still more by the effete policies of governments of past centuries, dislocated into modern life, from these there has come a great country and a great people, whose growth, change, and development promise to be practically endless.

Of my own country and of my own people you will not expect me, you would not wish me, to say anything disparaging. We are an old and respectable race, and by virtue of your descent you share that age, and you have brought over with you a full share of the respectability. But in transit you have lost that questionable virtue of extreme conservatism which we retain in every conceivable phase of life. We used to have mail-coaches protected against robbers by armed men, properly called guards, and we continue to call our railway servants guards, without the slightest reason save that they seem to be in some fashion successors to the blunderbuss-bearers of the eighteenth century. On the other hand, you very properly name the same officials conductors. We still build our railway carriages in compartments fitted to hold six people—confined boxes that are stuffy, inconvenient, wasteful of room, and dangerous—and we do this only because one hundred years ago we built our stage coaches on this pattern. Fifty years ago we thought, and we continue to think, that by sticking three of these old coaches end to end we must of necessity construct the best kind of vehicle for railway travelling. Untrammeled by tradition, you have contrived to build carriages far more convenient and suitable in every way. You have even sent them over to England for our use some ten years ago, but they had actually to be removed from some of our railways because the public would not use them.

I might gather further illustrations of that intensely conservative spirit which governs everything English. I might wander into the lines of religion and politics and hundreds of other sources, but I prefer to take one of which I can speak at length and in detail; one upon which I believe, if I read aright the compliment you pay me by asking me to appear here before you, I can speak with some authority.

In my early days the medical education of a British youth was not considered complete unless he had made a tour of the schools of France and Germany, and, like others, I felt of myself as was said of Proteus:

> "'Twould be a great impeachment to his age
> In having known no travel in his youth."

But I wish now that the time and money therein spent had been directed to the western instead of to the eastern continent; and I now venture to predict that ere long it will be to the medical schools of America rather than to those of Europe, that our students will travel, as did the apprentices of old before they settled down to the serious exercise of their craft.

For many years past I have been visited by numbers of my professional brethren from this side of the Atlantic, many of whom have settled down for days and weeks, and even months, to see my work. I have been overwhelmed by the kindliest invitations to visit this continent, but till now I have never ventured across. This delay is an instance of British conservatism, for it is very little the fashion amongst us to take long holidays. My American visitors have one and all impressed me with their possession of that feature of mind which in England I fear we do not possess—the power of judging any question solely upon its merits, and entirely apart from any prejudice, tradition, or personal bias. No matter how we may struggle against it, tradition rules all we do; we cannot throw off its shackles, and I am bound to plead guilty to this weakness myself perhaps as fully as any of my countrymen may be compelled to do. I may have broken free in some few places, but I know I am firmly bound in others, and my hope is that my visit to a freer country and a better climate may extend my mental vision.

To come to my intended illustration, let me briefly remind you of the early history of abdominal surgery. The first operation for the removal of an ovarian tumor was performed unwittingly in 1701, in a Scotch village, by Robert Houston, who began a tapping, and finished by making a successful ovariotomy. It was not until 1809, eighty-six years after Houston's case was published, that

his example was imitated, and even then it was not in Europe, but in the fresh soil of the backwoods of Kentucky that the young seedling obtained its first full growth, and from that time and from this country dates the history of abdominal surgery. But how slow the growth? In 1863, I heard my master, the Professor of Surgery in the University of Edinburgh, settle all this vast field of human progress in the few words, "abdominal surgery is abominable surgery." Syme, the greatest surgeon by far with whom I have ever come in contact, shared the views of his colleague in this matter, and I fear that in both of them the sentiments originated far less in the merits of the question before them than in their mutual dislike (almost the only sentiment they had in common) of John Lizars, who, having read MacDowell's manuscript when it was sent to John Bell, was immensely struck by the success of the heroic Kentuckian, and was desirous of following his brilliant example. Most unfortunately for humanity, the success of Lizars was of a very doubtful kind, and abdominal surgery had to wait for the advent of Dr. Charles Clay and Mr. Isaac Baker Brown. The story of the latter brilliant and unfortunate surgeon is now a thrice-told tale, and I can only repeat here what I have said at length elsewhere, that his disastrous downfall was a misfortune for humanity, delaying, as it did, the progress of abdominal surgery for fully a quarter of a century. The whole question of this progress lay in the peculiarly narrow issue as to whether the pedicles of ovarian tumors should be dealt with inside the peritoneum or outside it. Here again the new country was first in the race, for between 1820 and 1830 the decision in favor of the intraperitoneal treatment was given in America in such a way that the question ought never to have been reopened. The arbitrament of abdominal surgery between 1866 and 1876 was left in the hands of a man still living, and he carried through his practice a mortality so heavy as to be absolutely prohibitive of fresh enterprise. Mr. Baker Brown left off practice in 1866, with a mortality of ten per cent. with the cautery; whilst, after operating on a thousand cases, Sir Spencer Wells had a mortality of twelve per cent. with the ligature in the last hundred; and over the whole thousand the mortality was exactly twenty-five per cent. With such results as these, the marvel is not that the conservative surgeons cried out twenty years ago that the craft was in danger, but that the removal of ovarian tumors ever became an accepted operation at all.

As I have said over and over again, and as I shall never tire of saying, to Keith is due the whole credit of the modern development of abdominal surgery, and it has ever seemed to me specially hard that while wealth and a title have been the lot of the man who had done nothing but obstruct progress, to the author of our present proud position nothing has come save a good deal of misrepresentation and abuse.

In 1878, the doctrines and practice of Lister, after twelve years of preaching on the part of their author, had penetrated to London, and were taken up by Sir Spencer Wells and his assistants. I had practised all the details in their ever-varying form, as recommended by Mr. Lister, from 1866 onwards, and gave them up, one after the other, as I found they disappointed and hindered me. Finally, I gave the spray and its adjuncts a long and complete trial, a trial far more careful in its details than anything I ever saw elsewhere, this trial extending over three years. I have published in detail the disastrous results of this experiment, and at last I gave up all these unnecessary dangers, and since January 7, 1881, my practice has been entirely free from all these details. Since then my example has been followed by Dr. Keith, Dr. Bantock, and by my colleague, Dr. Savage, and the only surgeon now who uses the Listerian details for abdominal surgery is Mr. Knowsley Thornton. He still claims for Listerism the most of our present progress, in spite of the fact that Keith, Bantock, Savage, and myself have all far better results without Listerism than Mr. Thornton has with it. Mr. Thornton went so far recently, in a communication to Dr. Bigelow, which that gentleman published, as to say that his (Mr. Thornton's) bad results in hysterectomy were due to the fact that in this operation the Listerian details could not be effectually applied. But the facts of the practices of Mr. Thornton and Dr. Bantock, the two surgeons to the Samaritan Hospital, settle the question when they are contrasted. Mr. Thornton uses the Listerian details for hysterectomy as well as he can, and in twelve cases he has had five deaths, while Dr. Bantock does not use the Listerian details at all, and in twenty-two cases he has had only two deaths. The explanation of the difference will be evident to every one who has seen both of these gentlemen operate. To see Dr. Bantock do a hysterectomy is a lesson in surgery, and one from which I learnt a great deal.

To see my own work, I have been honored with the visits of a large number of surgeons from this continent, some of whom I see here now. I believe they one and all came with the belief that they would find I had some secret antiseptic agent, the use of which was the explanation of my success. If I have such an agent, it must be of universal existence in nature, for I have made some of my visitors take water from the tap and put it into the basins for the sponges and over the instruments and into the abdomen. I have made them drink it, and have offered it to them for analysis, and so far, I have not been detected in any exercise of magic. My visitors always ask to what I attribute my success, and I answer that I cannot tell. They frequently suggest that it is climate, and my answer is that our climate is the most variable and uncertain, the worst in the world. It is not fresh air, for the great majority of my operations, and always the worst, are done right in the middle of a large manufacturing town.

If I may formulate my own answers, they would be briefly to this effect. I have given up my life to this work and I engage in no other kind of practice; therefore, I have a constant weekly experience of five or six of these operations, sometimes as many as eight or ten. I pay the most minute attention to every detail, and maintain an absolute rule of iron over my nurses and my patients. I will not, if I can avoid it, operate in a private house, for there I have no control over either nurse or patient, still less over foolish friends. I can best illustrate the extent to which I carry discipline by telling an incident which occurred recently, of a kind of which I have had a few, but not many experiences. For my private hospital I have a rule that when a patient is admitted she must go to bed immediately. A lady with an ovarian tumor arrived after a journey of some hundreds of miles, and was asked by the nurse

told off for her, to go to bed. She said she would not do so till she had seen me. The nurse assured her that I would not come near her till she was in bed. The patient remained obstinate, and I sent a message to her that she must either go to bed or go home again, and she elected to do the latter, with much satisfaction to myself. She doubtless thought, and you may think, the rule in question is an absurd one, but the absurdity is only on the surface. It is a test of the patient's obedience and confidence in me, and I know very well that with a patient who begins by disputing my orders and doubting the wisdom of my directions I never could get on, and, therefore, it is better for both that we should have an early parting. My nurses I always train myself; in fact, I will not have one who has had previous experience, for I know very well that such a woman will inevitably, to save herself trouble, do something in a way she has seen done elsewhere, and probably for some purpose altogether foreign to my intention, and will therefore become to me a source of danger and annoyance.

Finally, I give great personal attention to cleanliness in every detail of my work. I trust no nurses or servants without overlooking; and I am constantly and at unexpected times turning up carpets, taking down shelves, and routing out cupboards. In this way, and by a process of weeding, I have obtained a large staff of good servants, and have founded a large establishment in which every available precaution is secured. I can give no other reasons than these for my success, and probably they will commend themselves to you.

There are, however, some causes intrinsic to the work itself, from which the success has sprung to a large extent, of which a few words may here be said with advantage. The first, of course, is the discontinuance of the clamp, of which I have said a great deal elsewhere. Whatever Sir Spencer Wells may say to the contrary, neither with nor without Listerism would anybody go back to the clamp. But the curious thing is that there are recent experiences in hysterectomy which would make it appear that it is not so much the clamp which has been to blame as Sir Spencer Wells's method of using it. Hysterectomy must always be a more serious operation than ovariotomy. Yet Dr. Bantock is now obtaining better results in removing the uterus with a clamp than Sir Spencer Wells ever got in removing simple ovarian tumors; and we must bear in mind that Sir Spencer always insisted that he used the clamp for his simplest cases—cases with long and easy pedicles.

Puzzling over the mysterious and startling contrast, I went to see Dr. Bantock operate, and amongst other things I found that he had given up using perchloride of iron for the purpose of tanning the stump. I asked him why he had done so, and he told me he was quite sure the use of the perchloride of iron had added greatly to the mortality of the clamp, because with a thick pedicle secured by the clamp it is impossible to close accurately the abdominal wound and prevent draining into the cavity. I did not at once accept Dr. Bantock's explanation, but I determined to use the perchloride of iron no more. Like everybody else, I was prejudiced in favor of the statement made by Sir Spencer Wells—that a putrefying stump would poison the wound, and therefore I could not make up my mind to allow it to remain without some kind of interference. Years ago, in blaming the clamp for our high mortality, I had pointed out the likelihood of this incomplete closure as being one of the causes, if not the chief cause of death. But I certainly did not suspect the perchloride of iron as being the fatal agent. A few days after my interview with Dr. Bantock, I had to perform a hysterectomy, and I dressed the stump with crystals of thymol. The patient died of peritonitis on the fourth day, and that the thymol had trickled into her peritoneum and had poisoned her we had proof enough. Since then, I have done hysterectomy twice without dressing the stump at all, and the patients are at present perfectly well. It will be curious, indeed, and no less instructive, if we find that Dr. Bantock is right, and that the use of perchloride of iron—the only contribution Sir Spencer Wells has ever made to abdominal surgery—should turn out to be the cause of his tremendous mortality. In any case, it is a remarkable example of how absurdly we are all governed by *à priori* statements—statements absolutely void of any arguments in support of them, but having been made by some one with an authoritative name and position, are accepted without doubt. If Dr. Bantock's brilliant results are obtained by others in the same way, then we have been going on destroying women with perchloride of iron merely because Sir Spencer Wells said we should use it.

As the whole aspect of abdominal surgery is at the present moment controversial, as the progress and practice of this part of our art form the chief objects of my life, you need not be surprised if I have made this address somewhat of a polemic. The greatness of the opportunity, the fact that an address given to you will be read where mere utterances of mine would be passed by, obliged me to take advantage of the opportunity you have given me to carry on the discussion. The course of this particular line of work has, as you know, taken a sudden bound of activity within the last few years, and the reason is a very simple one. The immense success in the removal of ovarian tumors such as threatened to destroy life with absolute certainty which followed the efforts of Mr. Baker Brown and Dr. Keith, led some of us—myself especially—to venture into regions where life was not necessarily, or, at least, not apparently threatened, but where suffering was persistent and incurable, and where the sufferers had been proved by protracted trial to be outside the powers of ordinary remedial measures. In a recent paper by Sir Spencer Wells, published in the *Medical Times and Gazette*, the argument is completely dislocated, and put in an altogether *'υστερον πρoτερον* fashion, and therefore I must here give a little attention to the views of that writer. He tells us that ovariotomy had at one time a mortality of seventy or eighty per cent., but I know not whence he gets his information. Doubtless it would be possible to find occasional examples of surgeons with limited experience having such a heavy death-rate, but such an isolated case would not yield a fair statement of the facts. I read a few months ago in an American medical journal that in Italy there had been one hundred cases operated upon, with sixty-three deaths; and the newspaper recorded the fact that "thirty-four surgeons were engaged in the sanguinary work." But when the work of men who can be called ovariotomists is examined, no such results are seen. Charles Clay was the first man who did an ovariotomy in England,

and his maximum of mortality in his first series of cases was forty per cent., but it speedily fell to twenty-five per cent., and this is very much what has been recorded by Sir Spencer Wells of his own practice.

In the paper of which I am speaking, Sir Spencer goes on to say that "afterwards when the strictest hygienic precautions were supplemented by antiseptics and improvements in operative details were generally adopted, success became so great that ovariotomy not only took its stand as by far the most successful of any capital operation in surgery, but the risk attending it in a favorable case could truly be calculated as little, if at all, greater than that attending any case of natural childbirth, and, as a necessary consequence, early operations could be advised with less hesitation." The statements in this sentence are wrong from beginning to end. In the first place, the mortality of ovariotomy in the hands of Keith and myself still remains at or about three per cent., and we have shown the least mortality yet available. The mortality of natural labor, on the other hand, is certainly not .25 per cent. The statement that diminished mortality has lead to early operations should be exactly reversed, for it is the early removal of tumors and the discontinuance of tapping which have largely contributed to our present splendid results. Sir Spencer Wells's teaching inculcated the practice of tapping and its repetition until the patient was within measurable distance of the grave, but his successors have reversed all this with infinite advantage to their patients, and we now look upon tapping as a sort of surgical crime. This material alteration in practice led us step by step in the direction I have previously indicated, and we began to discuss the greater advantage to which I have just alluded. Every specialist is familiar with a large class of miserable women who wander about from hospital to hospital or from consulting-room to consulting-room, seeking relief from their ailments unavailingly.

Let me take the first class to which Sir Spencer Wells alludes in his recent paper—cases of uterine myoma. There can be no doubt that there are hundreds of uterine tumors that give no trouble at all, but these are not the cases that come to us. If a woman has no pelvic trouble she does not present herself to the gynecologist, and if she has a uterine tumor which gives rise to no symptoms, that tumor of course remains undiscovered; but when she suffers from distress occasioned by pressure on viscera from severe hemorrhage or increasing size, she comes to us and asks for advice. Suppose we find her to be suffering from a uterine myoma, what are we to do? The answer to this question is like the answer to every other of a similar kind: each patient must be advised according to the circumstances of her case. If the tumor is small and the woman comparatively near her climacteric, and the hemorrhage such as can be moderated by a rest in bed and the use of ergot, then she should be advised to let the tumor alone. But if the woman be not near her climacteric, and the hemorrhage does not yield to treatment—especially if after a fair trial of treatment the tumor is found to be actively going on—then surgical treatment is demanded.

Of course, every practitioner of medicine and surgery does and always must carry on his work in his own way, and there can be no doubt that within certain limits the measure of his success stamps the rightness or the wrongness of his methods. James Syme used to teach us that there were three methods to conduct our professional business, but that there was only one way to real success. He said there were three interests involved. First in order, that of the patient; second, that of the professional colleague; and, third, that of the practitioner himself. Syme insisted that the several interests should be rigidly kept in the order in which he placed them, or things would be sure to go wrong. I have never heard sounder advice, and have never lost sight of it, and, so far as within me lay, I have striven to follow it. In the proposals of a new proceeding, two dangers clearly occur: the first, that of the enthusiastic upholder of the novelty, who may be disposed to run too fast in the new line; the second is that of the obstructive, who, merely a believer in the times that are past, can see no possibility of their improvement. The remedy for the first danger is a wholesome scepticism leading into just and careful criticism; the remedy for the second is more difficult, for it involves a patient endurance of much misrepresentation and a protracted combat upon the points of criticism which have no weight in themselves, and have an importance gained only by persistent reiteration. In the line of practice of which I am about to speak, the point most persistently urged against our new line of practice is that unnecessary operations are performed. Now this is an argument which it is extremely difficult to argue upon, because those who speak on the two sides of the question start from altogether different standpoints. Those of a past generation, like Sir Spencer Wells, apparently regard it as justifiable to perform operations in this department of abdominal surgery only when life is pronouncedly in danger; whereas, on the contrary, we of the younger school believe we are justified in extending our practice for the relief of suffering, and we regard this as a higher function than that of the mere saving of life. To end the discussion of this point I would point out that our critics endeavor to apply an arbitrary rule for the repression of abdominal surgery which has never yet been applied in any other department of the art. Let me ask, if we find a man suffering slightly with the early symptoms of a small calculus, do we not at once proceed to relieve him by removing it from his bladder? In fact, in the domain of what is called general surgery, has it not become an established practice to perform operations which are accompanied by very considerable risk of life merely for the rectification of deformities, such as bow-leg and knock-knee, which have not the remotest risk of life attached to them and which involve no kind of suffering? The ultimate court of appeal therefore comes to be the patient's own decision, and I do not find that patients prefer to go on suffering pain and the disabling effects of profuse loss of blood rather than submit to a surgical operation, the details and effects and ascertained risks of which are completely and candidly placed before them.

In the treatment of uterine myoma two alternatives occur, and these are both the subjects of very hot discussion on my own side of the Atlantic; they are removal of the uterine appendages and removal of the uterine tumor itself by the so-called supravaginal hysterectomy.

No one in Europe, at least only one authority so far

as I know of any importance, doubts that removal of the uterine appendages arrests menstruation completely in the great majority of instances, arrests the growth of uterine myoma generally, causes it to shrivel up, and in many instances actually to disappear. Mr. Knowsley Thornton, Dr. Savage, Professor Hegar, myself, and others have reported numerous cases in detail. I have published a long series in THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES for January, 1882, but Sir Spencer Wells dismisses us all in the brief sentence, "Vague, unsupported assertions have little influence upon the opinion of a thoughtful or a sceptical profession." Sir Spencer Wells must pass his retirement in some other way than in perusing the modern literature of his specialty and therefore his criticism need hardly engage our attention seriously.

The great majority of cases of uterine myoma which come to us for surgical treatment, can be quite satisfactorily dealt with by removal of the appendages, and it is an operation having a small and a steadily diminishing mortality. The arguments used against it are first that of its mortality, but this mortality is the inevitable death-rate of early work, and it is, therefore, not a permanent objection. It was an objection urged twenty-five years ago against ovariotomy, but against that operation it no longer holds good. The second objection is that myoma itself is not a fatal disease, but this is not an argument in harmony with my own experience. Even if it were a just one, however, it is admirably met by a plea entered at Ryde, in the discussion of my paper on the subject, to the effect that it is to the rights and relief of the majority that we must have regard, and that the function of our profession does not end with the saving of life, but it is chiefly that of relieving suffering.

Two other objections have been urged generally against the removal of uterine appendages that it sterilizes the patient and destroys their sexual appetites. Of course, a woman is completely sterilized by a uterine myoma ninety-nine times out of one hundred, so that the process of complete destruction of fertility is a matter of little moment. The other objection has been shown to be perfectly groundless, and even if it were not so, it could hardly be urged on the ground of morality that a woman should go on suffering because she ought not to suffer any diminution of that animal propensity which it is the chief object of the higher life of all religious culture to subject, and the subjection of which forms for all creatures the greatest difficulty of existence.

There are cases of myoma demanding surgical treatment upon which removal of the uterine appendages seems to exercise no satisfactory influence. Mr. Knowsley Thornton has made a very valuable suggestion, one which certainly deserves very careful consideration, that all cases of myoma requiring interference should first be subjected to removal of the uterine appendages and then to subsequent operation if it should be found necessary. The only objection to this that I can offer, at present, is an incomplete one. I have pretty well satisfied myself that there is one form of myoma on which removal of the uterine appendages exercises no control, a variety which I have named the soft œdematous myoma. But it is not easy to recognize this form of myoma until it has been removed. Again there are a few cases, very few I have found them to be, in which the appendages cannot be removed, and we must proceed to hysterectomy. Finally, the removal of uterine tumors has had such brilliant results in Bantock's hands, that I am in hope that a new era for hysterectomy has been opened out.

Another class of cases wandering about seeking relief, are those upon which I have operated in large numbers, and have found chronic and incurable disease of the appendages in the form of chronic inflammation of the ovary, chronic inflammation and occlusion of the tubes, these latter being occluded and distended by serum, pus, or blood. When I first published my work on this subject, there was, of course, a large amount of incredulity expressed about it, and this incredulity was not much lessened by the exhibition of a large number of specimens at various Societies, and their permanent exhibition in the museums of the Colleges of Surgeons. Many, particularly amongst my metropolitan brethren, loudly asserted that there were no such diseases, and Sir Spencer Wells stated, at the International Medical Congress in London, that if such diseases did occur, they must all go to Birmingham. But Dr. Kingston Fowler has shown not only that they exist in London, but that they are far more fatal than I had any idea of, and that they have been and are overlooked and misunderstood in the metropolis just as they were overlooked and misunderstood in my own practice previous to 1878. Concerning this incredulity, please distinctly understand that I do not blame anyone for it; it is a necessary part of all human progress. I do not even blame my metropolitan brethren, as they seem to think I do, for not discovering these cases and properly treating them. That is the fault of the mechanical school of gynecology, established by Simpson, and which exercises a far too great influence over this department of our art. During the last twenty years, displacements have had a great run, just as before that time everything was put down to ulceration, and no man considered himself properly armed for the treatment of disease unless he carried a speculum and a caustic stick about with him in his gig. The mechanical school revels in the sound and the pessary, both useful enough in their proper places, but when misused are capable of endless mischief, for many of the so-called displacements are now known to be constituted by chronically inflamed and adherent tubes and ovaries, capable of relief only by their removal.

You will ask me at starting, to tell you how these diseases may be recognized, and I have to answer that their diagnosis cannot now, and probably never may be a matter of certainty. They begin generally in some acute attack of pelvic inflammation, from which the patient dates all her troubles, and when you get such a distinct history you ought at once to be on your guard. This illness may have arisen, for instance, in a clearly defined and confessed attack of gonorrhœa, or it may be an attack of pelvic perimetritis occurring after a miscarriage or a labor, or it may have arisen in one of the exanthematic fevers or a simple cold. In some of the cases, however, you get no clear starting-point in the history, and then the diagnosis is generally more difficult. The symptoms are usually precise enough, yet unfortunately none of them is peculiar to the condition of which we are speaking. Pain is, of course, a

leading feature, as indeed it is rarely without pain as a chief incentive that patients consult us at all. This pain is complained of as being constantly present, greatly aggravated by walking and becoming intense for some hours or days before the period and lasting throughout its continuance. Menstruation is usually too frequent and too profuse. In the great majority of the cases the uterus is somewhat fixed, and a tender mass can be felt at one or other side of it, perhaps on both sides, and behind it. When the tubes and ovaries are down behind the uterus and adherent there, and this is by far the most common condition, the diagnosis to a beginner is extremely difficult. Nothing looks more certain and easy than the diagnosis of subinvolution and retroflexion, and without further consideration a pessary is introduced, with no other result than that of aggravating the patient's sufferings; in fact, I may say that at this point her troubles will begin to be serious, and she will wander about collecting various kinds of instruments from various practitioners, until she ends either a helpless or hopeless invalid, or dies from an attack of acute peritonitis.

In some of my most marked and most successful cases, there have been no physical signs at all, and I have felt myself reluctantly justified in interfering only by the manifest reality of the patient's sufferings.

Here let me just say a word about the much discussed question of subjective symptoms. Everybody has heard of the celebrated story told of Liston, that a hysterical girl persuaded him to remove a healthy limb for supposed disease of the knee-joint; but is there any other story of the kind known? If there is, I have not come across it. We certainly do meet with women who will tell incredible stories about their sufferings, but the stories are so inconsequent and contradictory that there is no difficulty in discounting them. Besides, they have no support from the presence of corresponding physical signs. A woman whose sufferings are real has a sequent narrative and will submit to treatment, while the woman who is a humbug flies off at a tangent the moment a suggestion is made that she should submit to an operation in which she risks her life. I have never yet known a woman submit to an abdominal section in whom I did not find abundant justification for its performance, even in cases in which I had been extremely doubtful about its real necessity before I undertook it. I have known many patients to whom I have made the proposal as a test of their reality, and who, much to my satisfaction, have speedily taken themselves off to some other practitioner.

As to the details of the operations in these cases, I have no time here to speak; indeed, I could deal with them satisfactorily only in a series of lectures. Suffice it to say, that the operations are very difficult, for the structures are always extremely adherent, and the operator has nothing to guide him save the erudition of his touch. Concerning the cases of occluded and distended tubes, some of my critics have suggested, without any experience, that something short of abdominal section might suffice for their successful treatment, such as tapping the tubes from the vagina; but a trial of this proceeding long ago satisfied me of its impracticability and its uselessness, and my growing experience constantly confirms me in the conclusion that we have no alternative.

I am often asked concerning the subsequent history of these cases, and I am able to say from the published details, that the great majority of them are relieved at once and completely by the operation. In some of them there remains a tenderness of the stumps, lasting for some months. In four very bad cases fecal fistulæ had formed, and in two the sinuses have healed and the patients are perfectly well. In the third case the fistula opens still at occasional intervals, and in the fourth case, by far the worst I have ever had, the patient being literally at death's door when the operation was performed, the fistula still remains open, some twelve months after the operation, and even here her health has so greatly improved that I am hopeful of its permanent closure in time.

I have occupied your time already at too great length, and yet have left myself no time whatever to speak of a great variety of topics within the limits of the subject of my address of which I fain would have spoken—subjects entirely novel, and full of the deepest interest alike to the practical surgeon and to him who takes but an interest of a literary kind in the progress of our art. In fact, it is a matter of regret to me that I cannot address such an audience as this in a series of lectures rather than in an address which must necessarily be brief. It is one of the great defects of a position such as I hold —a defect inherent in a special line of practice—that it practically shuts out its follower from any chance of being a teacher. Besides, I feel strongly this as acting to my own prejudice, and I am certain it is a misfortune that those who, like myself, are very largely engaged in work strictly limited to a department can never communicate as successfully the results of their experience as can those who are engaged in teaching. I regret, therefore, that I must pass over without mention the important field of new work which has been opened up within the last few years in the surgical treatment of the liver, spleen, kidney, and intestines. I cannot even stop to speak of many other, less striking, but no less important, subjects, such as the treatment of pelvic abscesses by abdominal section and drainage, though all these are of less importance, in so far that they excite but little hostility; and what I have to say to you further I purpose to limit to a brief discussion of a proposal, made by Dr. Robert Battey, for the production artificially of the menopause for the purpose of indirectly benefiting patients suffering from conditions more or less neurotic, the symptoms of which are apparently influenced by the recurrence of menstruation.

It must be perfectly clear to the most casual observer that this is a field of an extremely ill-defined character, one which at first sight offers but very intangible prospects of success, and in which the indications even of success must be very vague and indefinite. There can be no doubt that a large number of women suffer in such a way as to make it perfectly clear that if they were relieved from recurrent menstruation they would be improved; but there can be no doubt that the application of this idea—in itself a brilliant one—requires the utmost care. I have no sympathy with stupid obstructionists who, because they scent danger in the air, would absolutely prohibit its application; but I have sufficient regard for the expression of every kind of professional opinion to recognize the necessity for the full exercise of caution.

When the proposal was first made, I recognized this so fully that I selected for whatever experiments I should make in this direction, a disease concerning the reality of which there could be no doubt whatever—I mean epilepsy. It is a perfectly easy thing to recognize by two facts alone any case of genuine epilepsy from mere hysterical imitation. It was, I think, Dr. John Hughes Bennett who clearly established the facts that none but the true epileptics ever seriously hurt themselves during the attacks, and that after the fits are over the epileptic is always somnolent. It is certainly the case that in a large number of cases of epilepsy in women the incidence of the disease is concurrent with menstruation. It is also true that every epileptic woman whose case I have investigated is worse during the menstrual week than at any other time. In some cases, the epilepsy is absolutely limited to those days of the month during which the menstrual flow is in existence. It was, therefore, a perfectly easy thing to select a number of cases in which the experiment of Battey's operation seemed capable of justification.[1] For the purpose of trying the experiment, I selected six cases, and to these I have absolutely limited its application, though from the number of patients who have been sent to me for the specific purpose of having the operation performed, I suppose I might have been able, by this time, to have placed several scores of attempts on record. The reason of my careful restriction has been that I do not care to prejudice the results of my other work by complicating it with what seemed to me a doubtful kind of proceeding; but all my care has been to some extent fruitless, for I have been persistently charged by a certain class of writers with having performed a large number of useless and unnecessary operations in removing normal ovaries in women suffering from nervous disorders. Indeed, so late as July 5th last, Sir Spencer Wells wrote the following sentences, which, though they may have been intended for some one else, I cannot help but suspect were levelled at me. They run as follows: "Just now something more than a word of caution against rash, dangerous, and unnecessary operations is called for. We are startled by the reports of the removal of normal ovaries of young women suffering from nervous disorders, which may be exaggerated or imaginary; and it is to be feared that our professional honor is at stake, and that abdominal surgery, in its latest developments, is open to the denunciation hurled against the early ovariotomists; and that, with more reason than in 1850, Lawrence's question must be repeated, whether such operations can be encouraged and continued without danger to the character of the profession; and West's assertion that the fundamental principle of medical morality is outraged, cannot now be satisfactorily refuted."

Though I am fairly familiar with the literature of abdominal surgery during the last ten years, I am absolutely ignorant of anything which can possibly justify such ridiculous exaggeration. I have publicly challenged Sir Spencer Wells to indicate the proceedings to which he alludes, and to produce the evidence upon which he bases his charges; but up to the moment of my leaving England he had not taken up the gauntlet. It is a somewhat remarkable fact that in another journal, in the same month, the same writer actually pleaded in favor of the removal of tubercular lungs; that such an operation would be justifiable if it saved one patient in twenty of those operated upon, and it seems to me absolutely impossible to reconcile such a recommendation with the denunciation I have just read.

So far as my own work in Battey's operation is concerned, in not a single one of the six patients operated upon were the uterine appendages normal. In two of them, typical examples of cirrhosis, the pathological anatomy was carefully investigated by independent observers, one of whom was the well-known and accomplished pathologist, Mr. Alban Doran, by whom the appearances were fully described and figured in the *British Medical Journal* for Nov. 8, 1879. The results of these operations, in the first place, were that all the patients made easy and uninterrupted recoveries; the operations were performed after the most careful consultation, and with the full cognizance on the part of the patients and their friends of the results which were certain, and the entirely speculative nature of those it was hoped would be obtained. As I have already published the cases in detail, with the exception of the last, which was performed only a few weeks ago, I need not here repeat them save in general terms, and that is to the effect that in two cases the results are such as to justify completely the proceedings. In both of these the disease before the operation was so intense that it was threatening life, but now it is almost entirely subdued, and the health of the patients has been enormously improved. In one case the disease was entirely arrested for a year and a half, and though it is now returning, the patient has been transformed from a wretchedly feeble, anæmic, and broken-down girl into a healthy and robust woman, although affected by epilepsy almost as badly as before. In two others the disease has been greatly modified, and the health of the patients has been immensely benefited.

From this brief record, it is quite a matter open for discussion as to whether the continuance of the proceeding can be recommended, and I am bound to say that I have not myself a very strong opinion in the affirmative: but I think if I had a daughter with feeble health, the result of pronounced menstrual epilepsy, I think I would advise her to have the operation performed. From what I have seen of it myself, I think there can hardly be any risk about it, and if performed with the precautions I have indicated, I do not think it can be brought under the sweeping category of Sir Spencer Wells, as being either rash, dangerous, or unnecessary.

There is another argument, and I think one that may be said to have some moral force, in that, as it will assist in the prevention of the distinctly pronounced hereditary

[1] Dr. Thallon, of New York, has lately published an article in Seguin's *Archives*, which is an admirable illustration of the Teutonic process of elaborating a camel from the inner consciousness of the writer. Dr. Thallon seems never to have read what either Dr. Battey or I have written on this subject, and he has created a new term, against which I desire to enter a vigorous protest. He speaks of the "Battey-Tait" operation. There is no such thing. Dr. Battey's proposal is as different in its purpose, in its details, and in its application from my own as lithotomy and amputation. I need not enter into the further details of Dr. Thallon's criticism and conclusions, as they are reached solely by the utter absence of experience of the matters on which he has chosen to write.

tendency of the disease, we should at least hesitate before we entirely condemn it. Certainly a great deal more can be said for it than for the proposal of pneumonotomy for phthisis, on the assumption that the removal of a lung would only save one patient out of twenty. Removal of the uterine appendages for epilepsy would probably not kill more than one per cent.; and I am certain it would materially relieve fifty per cent.; it would improve the health of the great majority of patients, and I do not think it would make any of them worse than they were before the operation. I am hopeful, therefore, that the verdict of professional opinion will not be adverse to a fair and reasonable trial of Dr. Battey's proposal, and I trust that the freedom from the prejudice and shackles of tradition which we find on this side of the Atlantic will secure for it a fair field.

And now, in conclusion, let me thank you most sincerely; and not only you, but many other professional bodies, and large numbers of professional friends, for the kindly, I may say overwhelming reception I have met with at your hands. For many months before I left home there was hardly a mail arrived which did not bring me invitations of public or private hospitality, and these brought forth feelings of regret that my stay on this continent could not be prolonged for as many months as it will have to be limited to days. One thing I recognize in this above all others, and it is that you are treating me not on my own merits, but as a representative of a large body of men in my own country, to whom you have owed much in the past, and with whom you are in the present united in a common bond of brotherhood and community of sacred purpose. For the future, I predict that the unity and the union will be more and more complete. If it should be in the mind of any that in what I have said I have been lacking in detail, let me say again that the theme you gave me was far too wide to be satisfactorily and completely dealt with in one address. If, on the other hand, I should be adversely criticised as having spoken strongly upon matters in dispute, let my apology be that I have worked hard and long and earnestly in the field I have undertaken, and that no man can feel strongly without infusing into his words some tincture of the thoughts that govern his actions.

ORIGINAL ARTICLES.

[OFFICIAL.]

MEDICAL REPORT ON THE CONDITION OF THE SURVIVORS OF THE GREELY PARTY, WHEN RESCUED BY THE RELIEF SQUADRON.[1]

BY EDWARD H. GREEN, M.D.,
SURGEON OF THE U. S. S. THETIS, OF THE GREELY RELIEF SQUADRON.

As a preliminary to the medical history of the cases of the survivors of the Lady Franklin Bay Expedition, it is well to give a brief *résumé* of their mode of life at Camp Clay, their quarters, rations, etc., so as better to appreciate the condition in which they were found.

On September 29, 1883, Lieutenant Greely landed with his party at Baird Inlet after thirty days' exposure drifting on an ice-floe; the record left at that time stated the *party was all well.* Having sent an advance detachment ahead, which found and reported that a *cache* of provisions existed at Cape Sabine (fifteen miles further to the northward than he was at this time), it was deemed expedient to move the whole command up to that neighborhood rather than send for the provisions, and winter at Baird Inlet. Finally, on October 25th, they moved around to a point between Cape Sabine and Cocked Hat Island (lat. 78° 45′ N., long. 74° 15′ W.); the site of their winter-quarters was sheltered between high ridges of mountains, which screened them in a measure from the northerly and southerly winds. A glacier was situated at the foot of the mountains on either side of them about a mile distant. They constructed a house of loose rock and moss, the walls being three feet in thickness. The roofing consisted of old canvas stretched over a boat; the dimensions of the house were 25 feet long by 17 feet wide by 4 feet high, making a cubic air-space of 1700 feet, in this the twenty-five members of the party lived all winter, having a cubic air allowance of about seventy feet for each man. The whole party could barely squeeze in and lie at length, two or three being obliged to occupy the same sleeping-bag; the effect of this diminished air-space will be seen later on. Their hut was but 100 yards removed from the ice-foot of the sound, and 200 yards to the south of them was an artificial lake, from which they drew their water supply by melting up ice; as the sea water strained into this lake, they were drinking brackish water all the while.

On November 1, 1883, Lieut. Greely took a careful account of his stock of provisions, and found there was but a whole ration for each man (estimated as an army ration, about forty-six ounces of solid food per diem) for forty days. Doctor Pavy and he advised together, and it was with some reluctance that they determined to divide up the rations so as to make them last until March 1, putting aside from time to time, so that at the end they would still have ten days' supplies left with which to attempt the trip to Littleton Island, if the Straits were frozen over. Doctor Pavy did not think the party could exist on the ration during the winter, but the common voice was to make it go as far as it would; so each man was given the following daily allowance:

Meat and blubber,	4.33	ozs.
Bread and dog biscuit,	6.5	"
Canned vegetables and rice,	1.4	"
Butter and lard,	0.75	"
Soup and beef extract,	0.90	"
Berries, pickles, raisins, and milk,	1.	"

Making the daily allowance for the four months 14.88 ozs. During the winter the following amount of game was secured, which added to their stores: 2 seals, yielding about 120 lbs. of meat, one bear, yielding 300 lbs. of meat, 8 foxes (4 lbs. each), and 60 dovekies (uria brunnichii), a small bird, weighing about a pound.

March 1 found the party intact, with the exception of Sergt. Cross, who died in January with well-

[1] This paper was specially prepared for THE MEDICAL NEWS, to which it was forwarded by Surgeon Green, through the Bureau of Medicine and Surgery of the Navy Department.

marked scorbutic symptoms—the only case of pronounced scurvy that developed—and Hans, their Esquimaux hunter, who was lost in his boat while hunting seals, early in February. The Straits having been kept open during the winter by a succession of violent gales, the attempt to cross to Littleton Island had to be abandoned, and their ration was still further reduced to the following allowance: meat 6.8 ozs., bread and dog biscuit 3.2 ozs. The rest of the stores having been exhausted, the remaining supplies were divided up so as to last until May 12th. The sun had returned by this time, after an absence of one hundred and twenty-eight days, and those employed as hunters caught the shrimp (crangonidæ), a small crustacea, one-eighth to one-fourth of an inch long, consisting of about four-fifths shell and one-fifth meat. From 1 to 3 ozs. of these a day, according to the catch, were allowed in addition to the ration.

After the last reduction the party began rapidly to weaken and die. About the 24th of March the whole party was overcome with asphyxia, and nearly lost their lives, owing to the atmosphere being surcharged with carbonic acid. They had lit their alcohol stove in the hut to cook a meal, without previously having removed the rags from the vent-hole in the roof; the remaining oxygen of the air was soon consumed by the stove, and the whole party were seized with faintness, vertigo, and dyspnœa. It was with the greatest difficulty they struggled from their sleeping-bags, and stumbled and were helped into the open air, many fainting away and dropping unconscious after reaching the opening. Being poorly clad for a temperature such as prevailed outside at the time (—46° F.), many were frostbitten. The after-effects of this mishap remained for a long time, and weakened many of them.

After May 12th everything like a regular ration was exhausted, and they struggled on as best they could, catching the shrimps (which they boiled); gathering reindeer moss, which, when boiled, yields a mucilage similar to Iceland moss, and boiling up the sealskin linings of their sleeping bags, from which a gelatinous mass was extracted. It was not till they had exhausted the supply of moss around the camp that they gathered the black lichen (*crêpe de la roche*) growing on the rocks, and boiled it. Dr. Pavy urged strongly against its use, as he had the authority of Kane and Hayes that, when eaten, it would produce a diarrhœa which, in their weakened condition, would be fatal. They had no fuel for artificial warmth, and barely sufficient to allow for melting the ice for procuring drinking water and to cook a meal every other day; so that the living temperature of the hut for the winter was from 5° to 10° F.

They recognized the fact that the nearer they could approach a state of hibernating, the better were their chances of getting through. Only those employed as cooks and hunters exerted themselves much, and they were given a double ration. The rest occupied their sleeping-bags, and slept sixteen to eighteen hours out of the twenty-four. In answer to complaints of hunger, Dr. Pavy's motto was, "Qui dort, dine," which was philosophical without being filling.

There seemed to be but little acute suffering from the lack of food. It was only after the introduction of food into the stomach that the craving became great. For days they went without food without actually suffering. The deaths seemed to take place finally from heart trouble (hydrops pericardii). The feet and face became œdematous; for a day or so they would complain of pains over the heart; have a spasm of pain over the præcordia; a slight general convulsion, and all would be over. Their chief suffering during the winter was from constipation. Many went eight to ten days without a stool, and one as long as sixteen days; the feces became so hardened and impacted in the rectum that at each operation they were obliged to dig the feces out with their fingers, the abdominal muscles being too weak to extrude the mass. Nearly every one would faint after having a stool, from sheer exhaustion.

When it is considered that for nine months they were on the ration as detailed, had nothing but brackish water to drink, no artificial warmth, living in a temperature of 5° to 10° for the winter, with a cubic air-space of 70 feet per man, the condition in which the survivors were found will not be wondered at. There were but seven out of the twenty-five found alive. These were A. W. Greely, First Lieutenant, U. S. A.; Henry Biederlich, Hospital Steward; D. Brainard, Sergeant, U. S. A.; Morris Connell, Private, U. S. A.; Joseph Ellison, Sergeant, U. S. A.; Julius Fredericks, Sergeant, U. S. A.; Francis Long, Sergeant, U. S. A. The first four mentioned were taken on board the flagship "Thetis" and placed under my care, and with them this paper will principally be concerned.

On landing at the camp the condition of the party was so desperate that a delay of two hours was necessary to restore them sufficiently to permit their being removed on stretchers to the boats and taken off to the ships.

Morris Connell, Private, was *in extremis;* was pulseless, unconscious, and unable to swallow; limbs cold and respiration barely noticeable; auscultating over the heart, the sounds were heard very indistinctly. By propping him up, and forcing open the jaws, a teaspoonful of brandy was slowly poured into the back of the throat. The effect of the stimulant was soon noticeable, as a faint pulse appeared at the wrist; in ten minutes he could make an effort to swallow, when more brandy was administered, followed by some warm condensed milk at intervals. The rest of the party were served with brandy, milk, and beef essence, and finally transported to the ships.

The time and space would hardly be allowed me to give more than a brief detail of the cases, and as they closely resemble each other, both in symptoms and treatment, I will confine myself to the case of Lieutenant A. W. Greely more particularly, alluding to anything peculiar in the other cases.

June 22d, 11 P.M., A. W. Greely, Lieutenant, U. S. A., æt. 40. Disease, asthenia. On admission he fainted after being carried below in the ward-room, and vomited; administered ammoniæ spts. aromat. 6 c.c. (100 minims), renewed in ten minutes; placed him in a berth, gave a teaspoonful of raw, fresh beef,

minced; clothes were carefully cut off of him and heavy red flannels, previously warmed, substituted.

On examination his body emitted a sickly, offensive odor (as of stale urine); emaciated to a degree. The skin hanging from his limbs in flaps; face, hands, and scalp blackened with a thick crust of soot and dirt (having not washed or changed his clothing for ten months).

Nervous system: Excitable and irritable, at times almost irrational; eyes wild and staring; insists on talking, craving news, and demanding food; complains of no pain.

Digestive system: Tongue dry and cracked, heavy brownish-black coat; ravenously hungry, abdominal cavity hollow and lying almost in contact with the vertebral column; no movement of bowels for six days; liver dulness, on percussion, confined to right hypochondriac region.

Respiratory system: Respirations 12 per minute; auscultation and percussion reveal no abnormal condition of the lungs; vesicular murmur. puerile.

Circulatory system: Pulse 52, soft and compressible; auscultation shows marked murmur (blowing) in systole over base of heart.

Integumentary system: Skin cold and clammy, sickly odor emanating from it, shrivelled and sallow; temperature 97.2° (under tongue).

Locomotor system: Great muscular waste, unable to move or stand without support; body weight, 120 pounds; weight before leaving Fort Conger in August, 1883, 168 pounds.

Urinary system: No specimen obtainable.

Treatment, from 11 P. M. till 8 A. M., alternated every half hour; teaspoonful of raw, fresh beef (minced) with teaspoonful of milk punch; enjoined strict quiet; pulse then rose to 60 per minute, soft; temp. 97°.

23d. Nervous system: Mind still active and restless, compelled to allow him some home letters to read, after which he became more composed; has not closed his eyes; talks rationally, but shows loss of memory, as he often repeats himself.

Digestive system: Had a small, highly offensive stool; felt quite faint afterwards; passed considerable wind from bowels; abdomen tympanitic; tongue still dry and coated.

Circulatory system: Pulse slightly stronger, 60 per minute; respirations 12 per minute.

Integumentary system: Same offensive odor; temp., A. M., 97.8°; P. M. 98°.

Locomotor system: Still unable to raise himself up without help; muscles very soft and flabby; some stiffness and pain in the joints.

Urinary system: Urine passed in 24 hours 1630 c.c. (55 ozs.), sp. gr. 1014, acid, highly albuminous (one-tenth tube).

Treatment: Continue raw fresh beef, at intervals of an hour, with a raw onion finely cut up, added also milk punch, one-half ounce every two hours; no medication.

24th: No sleep; mind more tranquil, but too active; great desire to talk and read; less persistent in demanding food; complains of soreness in limbs; tongue presents a moister appearance; bowels slightly distended with gas, no stool; pulse 62, not so thready; heart sounds stronger; still a pronounced anæmic murmur; blood examined microscopically shows large increase of white corpuscles; at first the field (one-tenth objective) appeared filled with the nucleated corpuscles; close examination showed the proportion to be about one to twenty red; the red corpuscles show but little disposition to cohere and run into "rouleaux," and lacked the distinctive biconcave disk shape; edges full and round (not ragged); urine passed in 24 hours 1660 c.c. (56 ozs.), highly albuminous, no casts revealed by microscope; skin clammy, dirty mottled yellow; temp., A. M., 97.6; P. M. 98°; muscles sore; slight œdema of hands and ankles.

Treatment: Sponging with tepid water, afterwards briskly rubbed with flannels and a little linimentum saponis; four ounces, of oatmeal (thoroughly boiled) allowed in morning; beef essence, Liebig's, ʒj, in hot water every four hours; continue scraped beef and onion; no medication.

25th. Marked improvement; mind more tranquil; talks quietly without excitement; slept two or three hours naturally, awoke refreshed; tongue beginning to clean; had a large, dark, semi-solid stool; odor offensive in the extreme, evidently but little biliary secretion poured into the alimentary canal; pulse 65, some strength; respiration 14, principally costal; skin losing clammy feel, its emanations still sour and offensive; temp., A. M., 98.2°; P. M., 98°; muscles sore; ankles puffed.

Treatment: Shampooing muscles with dry cloths. No change in diet. No medication.

26th. Allowed to sit up in bed and read a little; slept six hours soundly during the night, mind tranquil, has a loss of memory of words; tongue cleaning, still has heavy coat at back; bowels moved twice, stools pitchy and offensive; abdomen tympanitic, considerable borborygmus. Pulse 65; heart sounds stronger, murmur still pronounced. Urine passed in 24 hours 1800 c.c. (61 ozs.), sp. gr. 1016; albumen not decreased; no change in condition of skin. Temp., A.M., 98°; P.M., 98.8°.

Treatment: Sponging and friction. Same dietary with tr. ferri muriat., 5 c.c. (80 minims) ter in die.

27th. Still extremely weak; voice stronger; mind easier; amnesic aphasia marked; appetite still morbid, always hungry, considerable flatulence; no stool; aspect of skin somewhat improved in appearance, still dirty yellow (no petechiæ). Temp., A.M., 98.4°; P.M., 98.8°; pulse 66; respiration 14; urine albuminous (1-12 tube) 1950 c.c. (66 ozs.) in 24 hours, sp. gr. 1018; muscles beginning to fill out, and are very soft.

Treatment: Dietary increased to 8 ounces of broiled steak in morning; continued tr. ferri muriat.

28th. Gaining strength; dressed and sat up for a couple of hours, then felt exhausted and returned to bed; mind quite tranquil; slept well; appetite still morbid; bowels moved, no change in character of stool; liver still inactive. Pulse 66, fairly good tone; anæmic murmur not so marked. Temp., A.M., 98.2°; P.M., 98°; urine passed in 24 hours 1860 c.c., (63 ozs.), sp. gr. 1017, albumen present.

Treatment: Takes food at five stated intervals: 6 A.M., oatmeal, 4 ounces; broiled steak, 8 ounces.

10 A. M., Liebig's beef essence, ʒj, in a teacup of warm water. 2 P. M., one soft boiled egg with milk toast. 6 P. M., raw minced beef and onions. 10 P. M., Liebig's essence of beef. Continue tr. ferri. muriat., 6 c. c. (100 minims) ter in die.

29th.—Dressed and was assisted to walk in ward-room a few steps; muscles soft; very weak; limbs filling out; body-weight 129½ pounds (gain of 9½ pounds for the week). Pulse 68; urine 1650 c. c. (56 ozs.) in twenty-four hours, albumen less; temp., A.M., 98°; P. M., 98.4°, normal; bowels moved naturally, stools still pitchy and offensive.

Treatment: Continue the same.

30th.—Sleeps naturally and awakes refreshed; allowed to read and talk; walks around for an hour or so with support; limbs filling out; feet œdematous toward night; appetite still morbid, unable to be satisfied with his allowance; good movement of bowels; albumen disappearing from urine; heart sounds stronger; temperature normal. Continue restricted diet and iron.

July 1.—Felt quite refreshed on awaking; had slept well during the night; enjoyed morning meal and ate without asking for more. As the sun was shining brightly, was assisted on deck, and sat in the air (well bundled up) for an hour; had but little appetite for midday meal; at 4 P. M., a small, dark, offensive stool; strained considerably, and was much exhausted afterwards (nearly fainted); administered spts. frumenti ʒss. in water at 6 P. M. Complained of severe pains in abdominal muscles and over the region of the liver (pains resembling hepatic colic); considerable febrile disturbance; pulse 98, temp., 100.2°; administered quiniæ sulph. 30 cgm. (4½ grs.) at 8 P. M.

2d.—Feels much prostrated and weak; muscular pains and soreness over abdomen and back; complexion sallow; appetite poor. Temp., 8 A. M., 98.8°; 12 M., 99°; 4 P. M., 99.2°; exhibited hydrargyri chloridi mit., 30 cgm. (4½ grs.), at 8 A. M. Repeated dose at 2 P. M.: bowels moved three times, last evacuation watery; felt weak, but free from cramps; headache disappeared; light diet of oatmeal and milk; discontinued tr. ferri muriat.

3d.—Still weak; muscular soreness over abdomen; no sharp pains; two loose evacuations from bowels; appetite returning; pulse 68; temp. normal; whiskey toddy ʒss ter in die.

4th.—Considerable improvement; pains have disappeared from muscles; tongue cleaner; complexion better; allowed to sit up to his meals. Urine much improved, albumen (⅛₀ tube), sp. gr. 1022. Resumed tr. ferri muriat., also vin. Portense ʒj ter in die before meals.

5th.—Gaining strength gradually; muscles soft; knees weak; encouraged to take some exercise daily, weather permitting, in the open air; digestion good; appetite under better control; liver still torpid; regular movement of bowels; skin clearing and has lost its clamminess; sleeps well; continue same treatment. From this time forth there was gradual improvement; blood again examined microscopically—showed marked diminution of white corpuscles. On *8th*, no albumen found in urine. On *12th*, anæmic murmur very indistinct. On *17th*, arrived at St. Johns; condition sufficiently good to warrant his going ashore for exercise; muscles still weak and sore; filled out rapidly.

19th had a slight attack of intestinal indigestion, was living ashore at the Consul's, having committed an error in diet; suffered for two days.

On *25th*, allowed to eat three full meals daily, with certain articles restricted; encouraged to exercise in open air. On the trip from St. Johns to Portsmouth, N. H., (*July 26th to Aug. 1st*), ran into damp, moist weather; felt much prostrated, and muscles ached; given quiniæ sulph. 180 cgm. (27 grs.), every night during the run. On being transferred at Portsmouth, his body-weight was 169 pounds, representing a gain of 49 pounds in six weeks: 9½ pounds the first week, 15 pounds the second week, 8 pounds the third week, 7 pounds the fourth week, 5½ pounds the fifth week, 4 pounds the sixth week.

Remarks.—Vital depression, as exhibited by the temperature is not marked; digestion fairly good all the time; nervous system soon calmed; microscopic examinations of blood exhibited no marked unhealthy character of red blood-globules, but steady decrease of white corpuscles under the influence of the iron; albumen disappearing; anæmic murmur disappearing, showing that it is simply due to hydræmic condition of the blood; liver not secreting; large gain in weight, due to rapid assimilation of food, owing to great muscular waste. Uurinary excretion large, 1950 c.c. (66 oz.), in one day, due doubtless to almost total inactivity of the sudorific glands.

U. S. S. THETIS, August 3, 1884.

On relinquishing medical charge of the survivors of the Lady Franklin Bay Expedition, prior to their transfer ashore for treatment, I respectfully submit extracts from the medical journal of this ship, showing their present physical condition and treatment.

1. A. W. Greely, First Lieutenant U. S. A., æt. 40 years. *Present condition:* Able to walk some distance without getting tired; muscles beginning to harden and tone; face still has a swollen appearance, and puffed; complexion sallow. *Digestive system:* Tongue clean and moist; appetite not abnormally large; bowels move regularly; stools large and dark colored, less offensive; passes less wind from bowels; no tympanites; at times heavy feeling over right hypochondriac region. *Circulatory system:* Pulse 78–82; good tone; auscultation over the heart shows almost total disappearance of anæmic murmur. *Respiratory system:* Lungs free from trouble; has slight dyspnœa on exercising. *Integumentary system:* Skin sallow; temperature of body 98.6°. *Urinary system:* Urine passed in twenty-four hours, fifty-six ounces; pale amber; acid; 1024 sp. gr.; no albumen. *Nervous system:* Mind tranquil; memory much improved; slight amnesic aphasia; sleeps well. *Locomotor system:* Muscles soft; has weakness, particularly in the broad muscles of the back (latissimi and trapezii); complains at times of cramps in the muscles of legs. *General condition:* Liver is torpid; muscular system lacks tone; is free from organic disease. *Treatment:* Rest; moderate exercise; dietetic; port wine before meals; pil. quiniæ

sulph. grs. iij at night; pil. ferri et strychniæ citrat. grs. iss after meals.

2. Morris Connell, Private U. S. A., æt. 32 years. *Present condition:* Sallow; muscles weak. *Digestive system:* Tongue clean, furred at the back; appetite abnormally large; bowels free, large stool daily; troubled at times with gaseous dyspepsia; bowels flatulent and tympanitic; liver contracted slightly. *Circulatory system:* Pains over præcordia disappeared; heart sounds normal; pulse regular, 74, lacks strength. *Respiratory system:* Normal. *Integumentary system:* Slightly œdematous about the feet; sallow; temperature of body normal. *Urinary system:* Normal. *Nervous system:* Sleeps well; mind active and retentive; no pains in body. *Locomotor system:* Muscles getting tone gradually. *General condition:* In fair health; free from organic disease. *Treatment:* Dietetic; tr. ferri muriat. ♏xv ter in die; exercise.

3. Henry Biederlich, Hospital Steward, æt. 28 years. *Present condition:* Suffering from chronic rheumatic arthritis in middle joint of ring-finger of left hand; has also at times flashes of rheumatism in joints and muscles. *Digestive system:* In good condition; suffers at times from gaseous dyspepsia; bowels regular; appetite not morbid. *Circulatory system:* Has anæmic murmur over the base of the heart; pulse dicrotic at times, 74 per minute. *Respiratory system:* Normal. *Integumentary system:* Face puffed, ankles œdematous, skin clear, temperature normal. *Urinary system:* Normal. *Nervous system:* Mind clear; has neuralgic pains at times in muscles of chest; sleeps well. *Locomotor system:* Muscles getting stronger and harder; joints at times stiff from rheumatism; middle joint of ring-finger on left hand chronically swollen. Is in fair physical condition and free from organic disease. *Treatment:* Quinine, small doses of potass. iodid., exercise.

4. D. Brainard, Sergt. U. S. A., æt. 28 years. Is in fair physical condition, performs all functions naturally; pulse good, temperature normal, urine normal, feet slightly œdematous, muscles in fairly firm condition. Free from all organic disease. *Treatment:* Dietetic, quinine, tr. ferri muriati, port wine.

5. Julius R. Fredericks, Sergt. U. S. A. In good physical condition; all functions naturally performed; pulse good, temperature normal. Has been under treatment of P. A. Surgeon Ames, on the "Bear."

6. Francis Long, Sergt. U. S. A. In good physical condition. Under treatment of P. A. Surgeon Ames, of the "Bear."

Very respectfully,

EDWARD H. GREEN,
P. A. Surgeon.

MEDICAL PROGRESS.

PERMANENT ANTISEPTIC DRESSING.—PROFESSOR ESMARCH, of Kiel, read a paper, at the Copenhagen Congress, on permanent antiseptic dressing.

The healing of all wounds *by first intention*, without suppuration, he said, is the most desirable issue. 2. This method of healing is most certainly obtained by the absolute preventions against infecting material, and by the complete rest of the wounded part. 3. Since every renewal of the dressings disturbs the wounded parts, and renews the danger of infection, a permanent dressing, one which can be left on the part until the wound is completely healed, is that which most nearly conforms to this end. 4. If the surgeon would avoid renewal of the dressing during the process of cure, the wound must be placed under such circumstances, must be so closed and dressed, that neither suppurative irritants nor foreign bodies shall remain in it, and that no blood or secretion from the wound can be retained. 5. The chief conditions for this result are: (*a*) Exact hæmostasis; (*b*) The avoidance of all spaces in the wound; (*c*) Free exit of all secretions; (*d*) The most careful antisepsis, and best antiseptics; (*e*) The use of compressible dressing-materials, which will absorb all the fluids; (*f*) Immobilization of the wounded part.

CONTRIBUTION TO THE SURGERY OF THE INTESTINE.—PROFESSOR MIKULICZ also read a contribution to the surgery of the intestine.

He has in two cases resected, with good results, an invaginated and prolapsed large intestine (in one case to the extent of twenty-eight inches, in the other twelve inches), using a typical intestinal suture (a double row of sutures, one of Lembert's suture, and a running suture for the mucous membrane). This operation is indicated in invagination and prolapse: 1. When reposition of the prolapsed intestine is impossible on account of the swelling; 2. When the prolapsed intestine is partly or entirely gangrenous.

As to the therapeutics of perforation of the intestine, in every case in which perforation of the intestine can be diagnosticated with some probability, laparotomy should be performed, the perforated portion sought out, and the opening closed by sutures, after freshening the edges of the wound. The operation is not contra-indicated by existing peritonitis, if the patient is not already in a state of collapse or sepsis. Mikulicz has successfully performed laparotomy in a case of this kind when there was purulent peritonitis from extravasation of the intestinal contents. This case was most probably one of perforation of a typhoid ulcer.

CONGENITAL SARCOMA OF KIDNEY, WITH OBLIQUE MUSCULAR FIBRES.—BROSIN reports (*Archiv f. path. Anat. und Physiol.*, Bd. xcvi. Hft. 3) a case—the seventh on record—of a child three years of age, who gradually became emaciated during the last two years of life, and had a large swelling of the abdomen, which became hard in the last year. No medical examination was made during life.

At the autopsy, a large hard tumor was found involving the left kidney. Microscopical examination showed it to be of sarcomatous structure; but wherever the connective tissue of the stroma was formed of fibrilli, with few nuclei, transverse muscular fibres were found. These often formed larger groups, and crossed one another in every direction. Of the cases of this kind hitherto reported, the youngest was seven, the oldest thirty-nine months.—*Centralbl. f. klin. Med.*, Aug. 2, 1884.

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SATURDAY, SEPTEMBER 6, 1884.

THE GREELY ARCTIC EXPEDITION.

THE Arctic tragedy with its accumulated woes, by which the civilized world has been at once fascinated and horrified, offers to the medical profession some important hygienic and physiological problems. It is, therefore, satisfactory to us to be able to lay before our readers the medical history, for this throws a clear light on the physical and, secondarily, on the mental state of the human wrecks rescued on the very border of eternity. Such a record of incredible suffering and hardships is not unknown in the annals of ocean explorations; but we do not find anywhere a scientific and exact statement of observed results such as that with which we are favored by Dr. Green.

The results of this expedition differ in one important point from former ones: but a single case of scorbutus occurred. The advance in our knowledge of the purpose subserved by the various kinds of aliment, permits the construction of dietaries adapted to the various exigencies of life. Given a route of the proposed exploration, the isotheral and isochimenal temperatures, and the kind and quantity of work to be done, a diet-table can be formed which will be exactly adapted to the conditions present, so that the body will be maintained at its maximum of efficiency. That the aliment furnished to the Greely expedition served its purpose, is shown in the fact that the party was in good condition when it reached its permanent quarters. The solitary case of scurvy would not have occurred, probably, if the other circumstances had been propitious in the affected individual.

Another lesson is the very small amount of food which may suffice to keep the human machine in a state of efficiency. Compared with some other historical examples, the food supply allowed each member of the party at Cape Sabine was liberal. It was in the aggregate nearly fifteen ounces. At the siege of Paris, the daily ration was at one time reduced to ten ounces of bread and one ounce of meat, or eleven ounces in all. The ration allowed the United State soldiers in the Andersonville prison, was five ounces of bacon and twenty ounces of unbolted corn-meal, which was not equal, in point of material available for nutrition, to that given the Greely party.

In view of the small amount of aliment allowed at the outset, and subsequently greatly lessened, an attempt was made to assimilate their lives to that of hibernating animals. This, we believe, was unwise. Although the amount of food and the low temperature precluded active exercise, they would have done better to accommodate themselves, as nearly as possible, to the conditions of health in normal surroundings. A hibernating animal has a store of fat laid up for consumption during the period of repose. The accumulating carbonic acid lessens the activity of the nervous centres, and induces a comatose state during which all the functions are inactive. Such a state of things is impossible to man, and the attempt to accommodate themselves to such abnormal conditions only produced a pathological state and accelerated waste. The air-space allowed them was entirely inadequate, and the enforced lack of attention to personal cleanliness prevented excretion by the skin. Hence animal heat was not properly developed, and the food taken was not efficiently utilized, either to promote nutrition or to maintain the body temperature. Suitably placed as to their hygienic surroundings, and the functions sufficiently exercised, the amount of food allowed at Cape Sabine, at the beginning of their stay there, might have been much lessened, and yet have proved sufficient.

In the process of slow starvation two beneficent results greatly lessen the terrors of the situation. At a certain point, the desire for food ceases, until the stomach is roused from its functional torpor by the introduction of some aliment. In those cases of voluntary fasting with the details of which the public is now and then regaled, it is probable that the experimenter experiences but little the pangs of unsatisfied appetite after the first few days of torture. Such was the experience of the Greely party.

The other beneficent experience of the starving, is the pleasing delirium in which feasting on sumptuous viands is indulged—in such a mode does Nature offer compensation in this dire extremity. But the delirium may take other forms. In the struggle for existence, when only the animal instinct remains, and men living in the state of animals lose the distinctive qualities of the civilized state, it is not surprising that mere savage feelings sway them entirely,

and hence the delirium, if not occupied with the pleasing illusions of feasting, may take the form of an aggressive animality.

THE CHOLERA CONFERENCE AT BERLIN.

IN the last two issues of THE NEWS we laid before our readers an extended abstract of the address of DR. KOCH at the recent conference held at Berlin for the discussion of the cholera question. The subsequent discussion was participated in by Virchow, Leyden, Hirsch, Fränkel, Schubert, Bardeleben, and others.

The important conclusions to be drawn from Koch's paper may be summarized as follows:

1. Cholera is the direct result of the lodgement and proliferation in the intestinal walls of a distinct bacterium, usually comma (,) shaped, but frequently, also, semicircular or s shaped, suggesting the apposition of two bacteria. It may also grow out into a spiral thread resembling the spirochæta of relapsing fever, whence Koch doubts whether it should be ranked as a bacillus, as a transition-form between a bacillus and spirillum, or a true spirillum.

2. The comma-bacillus is easiest found in the earlier stages of the disease, being later obscured by numerous other forms of bacteria. It is distinctive of the mildest as well as the severest cases, and has, therefore, an important diagnostic value.

3. It is capable of successful culture in broth, milk, on potato, and especially in gelatine, in which it grows peculiarly, producing a gradually extending liquefaction of the gelatine around the growing colony.

4. Thriving best at a temperature of 68° to 136° F., it is not destroyed by a temperature of 14° F.

5. It is, however, readily killed by drying, and it does not, therefore, pass into a state of latent activity or resting state, as does the bacillus of anthrax and vaccinia. The removal of the nutrient medium for 24 hours or even less, and an acid reaction, also destroy the bacillus.

6. Under ordinary circumstances the bacilli, introduced by the mouth, are destroyed in the stomach, but given a derangement of this organ due to errors of diet or other cause, and the bacillus is enabled to escape the action of the acid gastric juice and to reach the alkaline intestinal fluid, where it proliferates, sets up irritation, diarrhœa, and all the typical symptoms of the choleraic seizure.

7. Cholera can only spread by human intercourse, and cannot have an autochthonous origin, all observation going to show that the delta of the Ganges is its invariable source.

8. The harmful effect of the bacillus is probably not through its irritant action alone, because this is too limited in extent, but rather also through a poison or ptomaine which it generates, such as is produced by bacteria in putrefaction.

We have followed carefully the methods and reasoning of Koch, and have been favorably impressed by both. There is to us, too, a stamp of authority about these observations which cannot be admitted of those on tuberculosis. It cannot fail to be noted, however, that the whole subject is one of greater simplicity, and therefore easier of solution, than the tubercle question. At the same time we deem it premature to accept unqualifiedly the first and most important of his conclusions, because we believe that in a science like our own, where mathematical demonstration is impossible, we dare not, on the testimony of a single individual, however careful and accurate he may be, accept a conclusion until it is verified by others. The results of further observation must therefore be anxiously awaited.

The only observers who have as yet had the same opportunity as Koch are the French Commissioners, Roux and Strauss, who, while they admit the finding, among a large number of microörganisms, of one resembling the comma-bacillus, they do not attach much importance to it. They also call attention to the finding of a comma-shaped bacillus by Maddox, of London, in a reservoir of water, by Malassez in dysenteric stools, and by themselves in the vaginal mucus of a woman with leucorrhœa, and in the mucous uterine secretion of a woman who had commencing epithelioma of the cervix.

Koch himself admits that all efforts to produce the disease in the lower animals by inoculation of the bacillus have been unsuccessful, but argues against the conclusiveness of this fact as an objection, that cholera does not occur in any of the lower animals. It is true that pigs fed upon the choleraic material died of convulsions in from fifteen minutes to two and a half hours; but Koch says this must have been an "intoxication" rather than an infection, because another pig fed upon the intestinal contents of one of those thus killed was not affected. It will be remembered that it has, heretofore, been believed that certain lower animals are subject to cholera. Further investigations are evidently required in connection with this point.

The discussion which followed the address was limited in some directions by the fact that few present had had practical opportunities of the kind enjoyed by Koch, but was facilitated by the presentation of sixteen questions, of which we can now only dwell upon two or three of the more important. First of these is, of course, the question: "Is the infective material of cholera identical with the comma-bacillus?" To this Virchow answers "not proven," seizing at once the weakest point of Koch's position —that cholera has not been communicated through

its inoculation. At the same time, he admits that this is not an absolute refutation, and says further that if any one of the numerous organisms found in the dejecta of cholera be its cause, the probabilities are decidedly in favor of the comma-bacillus. The entire history of cholera, including its distribution, would seem to demand that a living organism is responsible, and the fact that Koch found that in certain cases the dejecta and the intestinal contents of cholera patients were made up almost wholly of cultures of this bacillus, that on the soiled linen—acknowledged to be the most dangerous means of communication—the growth of the organism is most active, leave it scarcely possible to conclude otherwise than that the bacillus is the essential cause. On the whole, then, we may say that Virchow inclines to accept the proposition.

Hirsch called attention to the fact that cholera morbus so often simulates in all respects Asiatic cholera, and furnishes some reasons for regarding it of an infectious nature. Koch says, in reply, that recent opportunities to investigate the morbid anatomy of this affection have failed to discover anything analogous to the comma-bacillus. Nor has he found it elsewhere, although here we must admit the force of Virchow's objections that many test-observations must be made before this can be admitted.

Another point of interest brought out in the discussion bearing on the diagnostic value of the bacillus was the practicability of its detection by any except those favored by the possession of laboratory facilities. The conclusion arrived at and shared in by Koch was that the difficulties are not so great, but that the educated physician anywhere may be qualified to detect it, particularly with the aid of cultures, which are especially distinctive in the case of this bacillus.

In the discussion as to the existence of a period of latent activity of the bacillus, came up the question of the origin of isolated cases of cholera, apparently communicated by the clothing carried in a trunk from a distant source of infection. In the same category must be placed the cases named by our esteemed contributor, Dr. Henry Hartshorne, in his letter in our issue of the 30th ult. Koch met the former objection by showing that the interval was within that of the viability of the comma-bacillus under circumstances favorable to its vitality—that is, moisture. Cases of the kind related by Dr. Hartshorne are always apocryphal, and can never be admitted in determining a scientific question.

Whatever may be the fate of the comma-bacillus, the address and the discussion must be regarded as most important and memorable. The series of questions were calculated to exhaust the subject thoroughly, while the professional eminence of the debaters insured and resulted in a cross-examination of the distinguished mycologist, in which he acquitted himself as creditably as in the original discourse.

MR. TAIT'S ADDRESS.

THE address on Abdominal Surgery made before the Canada Medical Association on August 25th, by MR. LAWSON TAIT, is given in full in this issue of THE NEWS. Its distinguished author manifests in it great ability, independence, and fearlessness—indeed some parts seem like a bold challenge to more than one person of acknowledged power and fame.

Let us first recognize the tribute Mr. Tait pays to the professional knowledge and skill of America in the prediction that soon students will come to the medical schools of this country rather than those of Europe, and seriously ask those who find nothing good in our system of medical education, whether this judgment of an eminent foreigner ought not to suggest to them the possibility of error in their constant disparagement of medical affairs here, and eulogy of foreign professional education.

Mr. Tait gives scant praise to Dr. Ephraim MacDowell, the great pioneer in ovariotomy; telling us that he, in 1809, imitated Robert Houston, of Glasgow, who, in 1701, made a "successful ovariotomy." It seems rather late in the day to adduce Houston's case as an ovariotomy, for this operation was simply a free incision into an ovarian tumor, evisceration of its contents, and "removal of several pieces of membrane." Such an operation done now would be called a partial or uncompleted ovariotomy, and the resemblance between an accidental, partial ovariotomy, and an intentional, complete ovariotomy is not so obvious that the great Kentucky surgeon should be spoken of as imitating the Glasgow operator, of whom, most probably, he had never heard. Mr. Tait's native land, Scotland, has enough professional glory without his taking a leaf from the laurel crown of MacDowell, and giving it to one who has no right to it, as the profession generally has judged.

Just praise is given Mr. Baker Brown, who certainly was one of the best operators London ever had. Mr. Tait clearly upholds strict cleanliness in abdominal surgery, in contrast with antiseptic practice, and decidedly to the advantage of the former. But this is a question that cannot be settled by the experience of one, or of half a dozen operators.

Omitting reference to the many hard blows given the most famous of English ovariotomists, some of which may seem to the casual reader as expressing needless criticism, probably the most interesting as well as the most valuable part of the address is that relating to the removal of the uterine appendages for uterine myoma, or for chronic and incurable disease of the ovaries or oviducts; this operation in the latter case is peculiarly Mr. Tait's, not only as to his being the first to perform it, but also as to the fre-

quency with which he has done it, and to his having had as yet comparatively few followers. The profession will be very glad to have from Mr. Tait so clear and condensed an exposition, as he has here given, of the conditions he regards as requiring his operation, and the results following it.

Battey's operation he eyes somewhat askance; but he has not given it full consideration; he has not weighed all the indications for it that Battey himself has presented, and therefore his judgment is only qualified and partial, not complete and conclusive.

It is to be hoped that in some of the great cities of the United States which Mr. Tait will visit before his return to England, he may be induced to give to the profession more at length his views upon abdominal surgery, especially concerning the operation with which his own name is connected.

CIRSOID TUMORS OF THE HAND.

IN a paper read before the Société de Chirurgie, and published in the *Union Médicale*, No. 65, 1884, POLAILLON, as the result of the study of 26 cases, including one of his own, arrives at the conclusion that the only efficient treatment of cirsoid aneurism of the hand consists in obliteration or destruction of the vessels of the tumor itself. Compression was futile in the 7 instances in which it was resorted to; and only 2 of the 13 cases in which the arteries of the forearm or arm were ligated were successful.

When the tumor is small, circumscribed, and non-adherent to the deep tissues, excision is indicated, and in certain cases the vessels may be destroyed by the thermo-cautery or chloride of zinc; but as a general measure, by far the surest and safest procedure, according to Polaillon, is the injection of a dilute solution of perchloride of iron, conducted under proper precautions. The circulation of the tumor having been arrested for ten minutes by compressing the brachial artery or the ulnar and radial arteries, a tubular needle is made to penetrate the vessels themselves, and not the connective tissue which surrounds them, as will be indicated by the escape of arterial blood, when the canula of the charged Pravaz syringe is passed through the needle, and from five to ten drops of the solution deposited in the vessel. One injection rarely suffices, but the operation is so free from danger that it may be repeated at intervals of five or six days until the tumor becomes hard, and its pulsation and souffle cease.

That this plan of treatment is not always successful is shown by Polaillon's own case, in which, ten years after an apparent cure, the symptoms were found to have recurred, and the tumor had increased in size. Had the author been thoroughly conversant with the literature of the subject, he would have had to add that injection is not always safe, as Spence has recorded a case in which it had to be followed by amputation; and Keen has, moreover, reported an amputation after injecting a traumatic aneurism of the hand with subsulphate of iron.

While it is true that hemorrhage may be excessive when the tumor is excised without taking the precaution to apply the bandage of Esmarch, it is none the less true the bleeding may be averted by resorting to that preventive measure, and that every case of excision as yet reported has been successful. As compared with the injection of perchloride of iron, we have no hesitation in declaring that excision, cautiously and skilfully practised, is the more rapid, safe, and efficient means of dealing with arterial varix, and in making this statement, we believe that we express the views entertained by the most experienced surgeons on this side of the Atlantic.

IN the thirty-six hitherto recorded examples of ligation of both common carotid arteries, either simultaneously or at variable intervals, there is not a single one in which the operation was demanded for spontaneous aneurism of both trunks. Hence, the case reported by RIEGNER, of Breslau, in the *Centralblatt für Chirurgie*, No. 26, 1884, in which this condition existed, is to be regarded as a surgical curiosity.

On the 21st of September, 1881, Riegner successfully tied the left common carotid of a man fifty-four years old, for a spontaneous aneurism of that vessel. On the 5th of April, 1884, the right artery was ligated for a similar affection of its trunk, the tumor having made its appearance a year and a half after the first operation. On the following day there were slight delirium and motor paralysis of the left arm, but these symptoms disappeared in twenty-four hours, and the patient was discharged on the eighteenth day.

THE Navy Department has promptly acted upon our recommendation of last week, and has instructed the Court of Inquiry to ascertain whether color-blindness on the part of any of the officers or men of the Tallapoosa was responsible for the collision at sea, by which that vessel was lost.

Fortunately, as the Board is sitting in Boston, it will be easy for it to obtain the requisite expert aid to conduct satisfactorily the investigation on this point, and without which it would be difficult for it to reach a correct conclusion. Tests with lanterns and flags, which naturally suggest themselves to the lay mind, have been found to be fallacious, since, under favorable circumstances, a color-blind person may make correct guesses at the colors by means of the difference in the intensity of light in which they appear to him. And in using Holmgren's worsted test, which is the only reliable test to obtain correct results, the worsteds must be properly chosen, and the examiner thoroughly understand the method.

SOCIETY PROCEEDINGS.

AMERICAN DERMATOLOGICAL ASSOCIATION.

Eighth Annual Meeting, held at Highland Falls, N. Y., August 27, 28, and 29, 1884.

(Specially reported for THE MEDICAL NEWS.)

THE Eighth Annual Meeting of the American Dermatological Association was opened at Highland Falls, on the 27th of August.

After the report of the Council and the transaction of the routine business of the Association, the PRESIDENT, DR. R. W. TAYLOR, of New York, delivered a brief introductory address, and then declared the meeting open for scientific work.

DR. W. A. HARDAWAY, of St. Louis, reported

A CASE OF MULTIPLE XANTHOMA OF THE SKIN, EXHIBITING THE PLANE, TUBERCULAR, AND TUBEROUS VARIETIES OF THE DISEASE.

In summing up the history of the case, the author called especial attention to the following points: that the bronzing of the skin preceded the development of the xanthoma by a number of years; that the eruption was perfectly symmetrical, with the exception of the lesions on the side; the involvement of the mucous membranes, and the undoubted implication of internal organs; the distribution of the tubercles on the side, which would seem to show that the nervous system exerted an influence in the development of xanthomatous lesions; the presence of such lesions in tendons and in the areolar tissue; and the probable implication of bone-structure in the same process; the evidence, although slight, of sugar in the urine; and, finally, the fact that some of the growths had disappeared.

From a study of this and other cases, and of the literature of the subject, he ventured to suggest that xanthoma was a diathetic affection, and that the connection of the disease with hepatic derangement was entirely secondary, or, in other words, that the jaundice occurred in consequence of the deposition of xanthomatous tubercles in the liver. He believed, however, that the liver was peculiarly prone to become the seat of these growths. It seemed to him, also, probable that in persons having what, for want of a better term, he would call "the xanthomatous diathesis," certain conditions of irritation or of unusual motion might provoke a local deposit *in situ—e. g.*, on the lids, over joints, etc. It seemed possible that his patient might owe his zosteriform deposits to an abortive attack of herpes zoster.

DR. S. SHERWELL, of Brooklyn, alluded to the old view that the liver was usually primarily affected in this disease, an opinion which he had never been able to corroborate in a large number of cases which had come under his observation. He thought that in the case reported, the affection of the liver and the consequent icterus were wholly secondary. In his own cases the patients were all in otherwise good health. One case in particular, which showed more than five hundred lesions, discrete and confluent, was that of a man in robust health with an admirable hereditary history, and with not the slightest evidence of hepatic derangement.

DR. J. C. WHITE, of Boston, said that he believed it extremely rare to find jaundice associated with xanthoma he himself having encountered it in only one instance of the many that he had seen of the disease, and he had paid especial attention to the point during the past twenty years. This remark he would apply to xanthoma of all grades of severity. He had seen only one case of xanthoma multiplex. He had often noticed a deposit of permanent pigment in both upper and lower eyelids, which rendered the contrast between the two colors very striking. He had never been able to trace any connection between xanthoma and a diathesis, but he had seen several cases of the disease in the same family. In listening to the reading of the paper he had been surprised at the statement that sugar had been found in the urine, in view of the low specific gravity of that fluid.

DR. L. A. DUHRING, of Philadelphia, remarked that a point of great interest in the case was the presence of the intense pruritus, beginning with the jaundice, and not with the disease. He had been much interested in tracing a possible relationship between the tumors formed in this disease and growths usually held to be of a different character, met with in the disease known as urticaria pigmentosa. He believed that two classes of affections had been described under this title, viz.: cases of true urticaria, with lesions of unusual persistency, and cases partaking more of the nature of xanthoma, with intense pruritus and pigmentation, and the formation of distinct papules and tubercles with the characteristics of urticaria. Such cases he regarded as identical with those which Tilbury Fox had described and figured in his Atlas under the name of "Xanthelasmoidea." Intense itching was also a feature of that disease. He had no doubt that a disease existed having a close relationship to xanthoma multiplex, but differing from it in that the lesions undergo involution, and run a definite course. He alluded to the fact that English observers, Dr. Morris in particular, claimed to have noticed spontaneous disappearance of xanthoma multiplex.

THE PRESIDENT, DR. R. W. TAYLOR, had also been unable to associate xanthoma with a particular diathesis, he having seen the disease in the strong as well as in the dyspeptic, the gouty, or the jaundiced. He had seen only one case of general xanthoma, which was in a woman in whom the entire body, as well as the face, was involved. If involution of the lesions ever did occur, he believed that it would take place on the body, for he thought that all would agree that it never did on the face. He recalled one case in which involution did take place, and in which it was attended with atrophy of the skin.

DR. HARDAWAY, in closing the discussion, stated that he had only the patient's statement in proof that involution of some of the lesions had taken place, and had not observed it himself. He had been very much interested in the osseous lesions which the case presented, which were involved in great obscurity. In the literature of the subject he had found only one allusion to such lesions, by Colcott Fox, who spoke of peculiar changes in the bones of one case, "due to the rheumatic or gouty state."

EVENING SESSION.

DR. J. NEVINS HYDE, of Chicago, read a paper entitled

A CLINICAL STUDY OF LUPUS ERYTHEMATOSUS OF THE HAND.

He described, in detail, the symptoms of the disease as exhibited by four patients under his observation. In each the discoid variety of the disease was displayed upon one hand, and of the four patients one only had facial lesions, the latter appearing years after full evolution of lupus erythematosus had occurred upon the right hand. In several of the cases the fingers were involved, and in one the palm was chiefly invaded.

From a study of the similar cases recorded in dermatological literature it appeared that the average age of the patients was somewhat over twenty years, nearly two-thirds of them being women, confirming thus the observation made by Kaposi, in 1882. The cases in which the hand or hands were involved were all reported by either English or American observers.

DR. J. C. WHITE stated that he had seen three or four cases of lupus erythematosus in which the hands alone were affected. He had seen other cases of disseminated lupus erythematosus in which although the lesions were widely scattered the hands were free. In all these cases he had been unable to recognize any general disturbances which would indicate a depraved condition of the system. He believed that cases of the disease in which the hands were involved were not so very rare, but that the affection was often mistaken for other things.

DR. SHERWELL had never seen the disease on the palms, but had seen it on the backs of the hands.

DR. TAYLOR had seen two cases of this variety. They were well nourished, and seemed free from any diathetic taint.

DR. HYDE stated that his main object in writing the paper was to point out the ease with which the affection could be recognized, and to enrich the scanty literature of the subject.

DR. S. SHERWELL then offered

A SUGGESTION RESPECTING THE TREATMENT OF ACNE AND ACNE ROSACEA IN THE MALE SUBJECT.

He stated that while in the text-books on dermatology much stress was laid on disturbances of the gastro-intestinal tract as reflex causes of the diseases in question, but little attention was usually given to disorders of the genital apparatus in the male. In America only two authors had recognized the importance of such disorders, viz., Piffard and Hyde. He fully coincided with them in this respect, and after speaking of the benefits which he had obtained from the use of ergot in these diseases occurring in the female, he proceeded to call attention to the use of the cold steel sound in the male. He believed that in some of these cases there was a condition of chronic passive hyperæmia of the urethra, especially at the junction of the bulbous and prostatic portions, in relieving which the use of the cold sound was often of great benefit. He detailed a case in a young man, and alluded to another which closely resembled it, in which he had, at various periods, treated the disease (acne rosacea) with local agents as well as measures directed to the improvement of the general health, with but temporary benefit. Finally, he had resorted to the gentle introduction of a cold sound at intervals of, at first, three days, and later, of a week. Improvement in the condition of the face began almost immediately, and now the patient was almost well. During this period no change had been made in the treatment in other respects.

DR. A. R. ROBINSON, of New York, supposed that all would agree that the cause of acne was usually some disturbance which acted in a reflex manner, except in strumous cases, in which, of course, cod-liver oil would render great service. Of course, if urethral irritation were present, the use of sounds might do good, and he thought the suggestion an eminently philosophical one.

DR. G. H. FOX, of New York, called attention to the fact that patients, after putting themselves under a physician's care, often made great changes in their hygienic regimen, with or without instructions, and he thought that, in many cases, this might be the true cause of an improvement which the physician might attribute to some special plan of treatment. The suggestion concerning the use of the sound impressed him favorably. He had seen eczema of the anus and scrotum relieved by the passage of sounds.

DR. SHERWELL was positive that there had been no change in the regimen of the two cases which he had described, and the symptoms of intense irritability of the urethra at the point mentioned had been rapidly subdued by the use of the instruments.

DR. JAMES C. WHITE then reported

A CASE OF UNILATERAL CHROMIDROSIS,

in a workman in a sugar-refinery, whose shirt had been stained of a bright-yellow color for a period of several months. After wearing the garment for a few days, the left side, from the shoulder to the flap, looked as if stained by saffron. There was apparently no excessive perspiration of this side of the body, nor were the patient's garments stained at all elsewhere. An analysis of the material absorbed by the shirt showed that it was of an oily character, readily extracted by ether, and yielding peculiar absorption-bands by the spectroscope. Its nature was not more definitely determined. Its source—*i. e.*, whether excreted by the sweat-glands or sebaceous glands—was also uncertain. The color was not due to the presence of bacteria, which have been found in some of the few cases of yellow sweat on record. The affection was immediately controlled by local treatment, and had not recurred after an interval of four months' observation.

DR. WHITE also reported some

CASES OF DERMATITIS SUPPOSED TO HAVE BEEN CAUSED BY CONTACT WITH ARSENIC.

He gave brief notes of three cases of *arsenical dermatitis* in connection with the report of a train of uncommon cutaneous manifestations in a mother and her new-born infant, after confinement within a chamber the walls of which were covered with arsenical pigments. The object of the paper was to raise the question, How far is the apparent case of "pityriasis maculata et circinata" in the mother dependent upon the presence of arsenical compounds in the atmosphere of the lying-in chamber, an affection concerning the etiological relations of which nothing is known? In

the infant, the symptoms were of an eczematous type, with unusual manifestations of intertrigo.

DR. SHERWELL said that the paper recalled to him an obscure case of bullous eruption now under his care (which he had called pemphigoid). The bullæ were large and very tense, sprang up rapidly and on all parts of the body of the patients—a man and his wife.

DR. WHITE asked if they had recently landed, and, on being answered in the affirmative, said that they were probably cases of mosquito-poisoning. He had seen cases of bullous eruptions in persons who had never before been exposed to the attacks of these insects, in which the lesions were often as large as pigeons' eggs. He alluded to a case of the kind in which lesions appeared during the winter, when no mosquitoes were about. On visiting the home of the patients he found that they lived in a damp, cave-like place, in which he found numerous large and active mosquitoes. He thought the presence of the bullæ on the body and thighs in such cases could be explained by the throwing off the covering of the bed during sleep. He felt certain that if Dr. Sherwell would investigate he would find that his cases were of this nature.

(To be concluded.)

CORRESPONDENCE.

THE EIGHTH INTERNATIONAL MEDICAL CONGRESS.

(From our Own Correspondent.)

COPENHAGEN, August 17, 1884.

THE Eighth International Medical Congress is among the things that were. Its promoters and managers have good reason to be proud of the results they have obtained, the number and character of the papers presented, the interest manifested in the work of the Sections, and the magnitude and splendor of the social entertainments provided. When it is remembered that the total population of the kingdom of Denmark is only half that of London, one can hardly express too great admiration for and astonishment at the hospitality with which Copenhagen has received her guests.

The total number registered as members of the Congress was seventeen hundred and forty, and the number of foreigners present was greater than at any previous Congress, even that at London not excepted. Of the Danish members many were not physicians. No credentials were required; apparently any one could register, and obtain a ticket of membership, on paying the fee, which for foreigners was twenty kroners (about $5.60), and for Danes fifty kroners (about $14.00).

The opening of the Congress in the hall of the Palace of Industry, on Sunday, August 10, was an impressive scene, although not so imposing as the opening scene of the London Congress in St. James Hall, owing to the fact that the room was much smaller, and there was no platform upon which to gather the notabilities in full view of the audience. The ceremony was very simple, consisting of an address of welcome by the President, Prof. Panum, and short congratulatory addresses by Paget, Pasteur, and Virchow, after which the President again mounted the rostrum, and gave a history of the organization of previous Congresses. The King and Queen of Denmark, and the King of Greece, with many Court officials, were present, but their part in the ceremony was entirely a passive one.

On the evening of Sunday, the President gave a dinner at the Hotel d'Angleterre to the notabilities of the Congress, about two hundred guests being present. According to the Danish custom, speaking began after the first course, and continued at intervals throughout the dinner. On this, as on most other occasions of a like character during the Congress, no American was requested to speak, it being apparently considered that Sir James Paget should always represent all the English-speaking members of the Congress. Certainly, no more eloquent orator could have been found; but the American representatives were nevertheless somewhat surprised and annoyed at the complete omission to recognize the United States as a separate nation.

The arrangements for registration were good. All who had, prior to August 1, notified the authorities of the Congress of their intention to be present, found their cards of membership duly prepared and ready for them on their arrival.

On Monday morning, the work of the Sections commenced, and went on for the most part smoothly and according to programme. The absence of Mr. Lister, who was to have presented the first paper in the Surgical Section, created some confusion in the arrangements of that Section; but there was abundance of material to fill the gap.

Monday evening was devoted to entertainments by the various Sections of the specialists connected with each department. This proved to be an excellent arrangement as a means of bringing together socially those who are interested in the same subjects, and is an example which might well be followed in future meetings of this kind.

The address of Pasteur in the general session, on Monday afternoon, was merely a repetition of what he has already published with regard to hydrophobia, with the addition of the report of the Commission appointed by the Minister of Public Instruction in France to verify his statements. Pasteur looks very well, but moves slowly and with some difficulty, not having complete control over the muscles of one side.

On Wednesday, the Congress took a recess to permit of an expedition to Elsinore and the Castle of Kronborg, celebrated as the scene in which is laid the play of Hamlet. A very elegant lunch was provided in the Castle by the Reception Committee, and, after the lunch, the company went out on the grassy ramparts overlooking the sea, and were served with coffee. The day was pleasant, and the whole scene was exceedingly picturesque.

On Thursday evening, the city of Copenhagen gave a dinner to the Congress in a temporary building erected for the purpose at the water's edge. Twelve hundred persons were seated at this dinner, which was elaborate and exceedingly well served. During its progress, steamers gaily decorated with flags were constantly passing in view, the water-front being simply one large window. Music, singing, and speeches came in between the courses, and at the close the whole party was taken by boats to the Tivoli gardens, about a mile distant, where there was a grand illumination, a concert, fireworks, etc. Taking it altogether, this entertainment

surpassed anything of the kind which has occurred at any previous Congress.

I shall not occupy more space with descriptions of the social features of the Congress, and will only say that they have been all that could be desired. A good, plain, simple lunch has been provided every day for the members of the Congress on a plan essentially the same as that followed at Philadelphia in the Congress of 1876.

With regard to the scientific work of the Congress, the general feeling is that it has been satisfactory both in quantity and quality. This, however, the readers of THE MEDICAL NEWS can judge for themselves when reading the reports of the proceedings of the several Sections.

With regard to the next place of meeting of the Congress, there was at first considerable difference of opinion. It was known that an invitation would be extended from America, and the English, Scotch, and Irish members were in favor of its acceptance. The French and some of the German members did not wish to accept it, because of the time and expense required, and also from fear of sea-sickness. Virchow desired to have the next Congress at Berlin; but no formal invitation was presented, and the general feeling, even among German physicians, seemed to be that the time has not yet come for the Congress to go to Berlin. An invitation was presented from Rome; but Italy has already had one Congress, and Rome is very malarious in August and September. St. Petersburg was also talked about; but after the formal invitation from American physicians was presented to the Congress by Dr. Billings, it became evident that it would be accepted, and this was accordingly done on the last day with general applause. Many of the prominent members of the Congress declare their intention of going to Washington in 1887, and it is probable that, when the time comes, most of them will carry out this purpose.

The American Committee of Organization for the Washington Congress will have a difficult task before it, and it will require the support of the whole profession of the country to make it such a success as it ought to be made; but if American physicians take hold of the matter in earnest, there can be no doubt of the result. If the members of that Congress leave Washington as well satisfied as the members of the present Congress, taken as a body, feel in leaving Copenhagen, it will be a great success.

(*From another Correspondent.*)

COPENHAGEN, August 16, 1884.

The Eighth Session of the International Congress opened at Copenhagen, according to programme, in the presence of their Majesties, the "Kongen of Danamark and le Roi des Hèllenes," on Sunday, August 16, at 1 P.M., with all the pomp and glitter of a regal ceremony. The Exposition building was gaily decorated with flowers and graced with the flags of all nations as the assembled delegates and visitors crowded into the hall. The whole array of Denmark's livery was on the street in front, where were gathered, to witness the imposing spectacle of the arrival of two kings, such a multitude of people as to keep the police busy in clearing the road.

Every member of the Congress had had put into his hands before arrival at the hall a greeting on the part of the civil authorities, in the form of a paper faced with a very good portrait of Pasteur, who is evidently the hero of the hour, as all the prominent shop-windows display his picture in the most conspicuous place. Photographs of Sir William Paget, Gull, Esmarch, Donders, Virchow, Chauveau, Axel Key, Koch, and others are also to be seen here and there. The greeting appears in the Danish, German, French, English, and Italian languages, and declares a cordial welcome to all the guests. The salutation runs as follows:

"*To the Eighth International Medical Congress:*

"The Danish medical state, the citizens of Copenhagen, and the entire Danish people do, to-day, welcome the Medical Congress in the capital of Denmark.

"It is with a feeling of pride that Copenhagen welcomes the celebrated representatives of one of the most advanced sciences.

"The medical science with its humane purposes has, in preference to all other sciences, a specially international character. No other profession than the medical is at the same time so deeply connected with the daily life of mankind and with the highest problems of human knowledge, no other calling has to a higher degree made itself deserved of suffering humanity and more contributed to softening the evils that are the unavoidable consequences of growing civilization.

"It is with gratitude that the Danish medical men, in the name of the whole people, have accepted the appeal to become hosts of the Eighth International Medical Congress. This honor involves, that the great world does not look upon Denmark as a country so distant from the great thoroughfare of civilization that it should be unable to find a place of meeting large and rich enough to give room for its studies, so fertilizing and blessing to mankind.

"Denmark, certainly, does not rank high in the council of the nations of the world, yet in our little country constantly reigns a feeling of the necessity to small nations of trying their utmost to keep pace with the other nations, where not the material but intellectual faculties are dominating. Denmark can, with a just feeling of pride, point to a number of men in more than one respect deserving well of mankind. Denmark is able, if it be not in every respect, to display scientific institutions, not grand, perhaps, but nevertheless institutions up to the claims of modern science.

"It is with these feelings that the Danish government, the Danish people, the magistrates of Copenhagen, and our medical men greet the bloom of the medical state of the civilized world, and it is with the fullest assurance that from all parts, high and low, there will be shown our guests every kind of friendliness and hearty welcome.

"A welcome to the members of the Medical Congress."

After a speech of welcome by Prof. Panum, President of the Congress, the lions of the occasion were put on exhibition with short addresses, Profs. Virchow, Paget, and Pasteur, eliciting the heaviest rounds of applause.

Foreign members of the Congress suffer great inconvenience from their inability to learn from the newspapers anything that has been done in the Sections

which they have been unable to attend. For there is no daily paper published in Copenhagen, a city of 300,000 people, in any other language than the Danish. Since the appropriation by Prussia of Schleswig-Holstein, the biggest half of Denmark, a deep feeling of animosity is cherished against the Germans everywhere: in Copenhagen, all German papers have been suppressed. In any American city the Congress itself would issue daily reports of the proceedings of the day before, but here there is nothing but the bulletins announcing the work of the day. The consequence is no one not understanding Danish can be informed of the work of any Section other than the one he attends.

THE MEDICAL SECTION

met in an upper lecture-room of the University building, and opened with a report by PROF. AUSTIN FLINT *On a Uniform Nomenclature of Auscultatory Sounds in the Diagnosis of Diseases of the Chest.*

At the meeting of the International Medical Congress, in London, in August, 1881, the following resolution was adopted by the Section of Medicine:

Resolved, That a committee be appointed to report to the Medical Section of the next Congress, wherever it may meet, on a uniform nomenclature of auscultatory sounds in the diagnosis of diseases of the chest. The following were appointed members of this committee:

Prof. Austin Flint, of New York, Chairman. Prof. Ewald, of Berlin; Prof. d'Espine, of Geneva; Dr. Douglas Powel, of London; Dr. F. A. Mahomed, of London.

At a meeting of this Committee in London, it was agreed that each member of the Committee should send a report to the Chairman, and the Chairman engaged to send to each member the several reports, or an abstract of them, the subsequent report of the Chairman to the Congress to be based on the reports collectively.

The Chairman of the Committee has received reports from each member of the Committee. The result of the comparison of the several reports is a very close approximation to a uniform nomenclature of auscultatory sounds. The points of difference relate to the following sounds, as regards either the names or their definition:

1. The respiratory sound denoting pulmonary cavity.
2. The dry and moist adventitious sounds produced within the bronchial tubes.
3. The scope of the terms crepitation, râles crépitants, Knisterrasseln.

Dr. Flint read only the conclusions of his report, and presented for inspection the following tabulated lists of terms to be used as synonyms in all lands.

Criticisms upon this report having been made by a number of members, it was decided to adopt this list as a provisional report, to continue the same Committee, to enlarge it by the addition of members from other lands, and to dispose of the subject at the next annual session.

DR. S. LAACHE, of Christiana, then read a paper on the *Value of the Later Investigations of the Blood Corpuscles in Anæmia and Leukæmia.*

The value of these researches lies in the great precision with which anæmic conditions can be understood. By means of the changed and much simplified methods of Vierordt and Welcker, and, later, of Malassez and Hayem, the clinician can now determine with tolerable certainty not only the relative number of the corpuscles, but also the coloring power of the blood, whilst formerly these could only be recognized in an uncertain degree.

In anæmia after hemorrhage both the number of the red corpuscles and the amount of hæmoglobin in the blood may be far less than fifty per cent. without causing immediate death, and without restitution to health being impossible, even though new blood be not added by transfusion. During the process of regeneration the formation of new hæmoglobin does not take place so rapidly as that of the red disks. In other cases of secondary anæmia the decrease, by complicating hemorrhages, of the coloring matters of the blood is generally but little proportional; cancer is an exception, though only in this case when the general state of nutrition of the patient is essentially changed.

In chlorosis two forms must be recognized, according to the proportion of the red disks: the one with either no, or only a very unimportant affection of the red disks—pseudochlorosis; and the second, true chlorosis, in which the red disks are affected, and sometimes very considerably. In chlorosis not only is the coloring power of the blood reduced to a greater or less degree, but also the number of the red corpuscles, the former being generally most affected. The distinction of these two forms is important, since it is in true chlorosis that iron exerts its well-known action. This is due to the fact that by the use of large doses of iron an active formation of new red disks and hæmoglobin, especially of the latter, takes place.

In pernicious anæmia the number of the red disks falls below 500,000 per cub. mm. without causing death, and without the impossibility of restitution to health. The proportion of the red disks is, in this disease, greater as a rule, and they contain more hæmoglobin than is normally the case.

Whilst the proportion of the white corpuscles in all

PALPATION.

BRITISH LIST. DR. POWELL AND DR. MAHOMED.	AMERICAN LIST. DR. AUSTIN FLINT.	GERMAN LIST. PROF. EWALD.	FRENCH LIST. PROF. D'ESPINE.
1. Vocal fremitus.	Vocal fremitus.	Stimmfremitus, oder Vocalfremitus.	Vibrations thoraciques.
2. Rhonchal fremitus.	Rhonchal fremitus.	Rhonchofremitus, oder Bronchialfremitus.	(Not included.)
3. Friction fremitus	Friction fremitus.	Pleuritisches resp. Pericarditisches Reiben.	Frottement.

PERCUSSION.

1. Tympanitic resonance.	Tympanitic resonance.	Tympanitischer Schall.	Son tympanique. (*a*) grave, (*b*) élevé.
2. Amphoric resonance.	Amphoric resonance.	Metallklang.	Bruit de pôt fêlé.
3. Diminished resonance. Dulness.	Diminished resonance. Dulness.	Dämpfung.	Submatité.
4. Absence of resonance. Flatness.	Absence of resonance. Flatness.	Absolute oder starke Dämpfung.	Matité.
5. Increased resonance.	Increased or vesiculo-tympanitic resonance.	Hypersonorer Schall.	Son pulmonaire exagéré.
6. Bell sound.	(Not included.)	(Not included.)	(Not included.)

AUSCULTATION.

First Group. Varieties of Breath Sounds.

1. Exaggerated Syn. Puerile. Compensatory. Supplementary.	Exaggerated, etc.	Verschärftes Athemgeräusch.	Respiration exagérée.
2. Diminished. Syn. Feeble. Weakened vesicular murmur.	Diminished, etc.	Abgeschwächtes Athemgeräusch.	Respiration diminuée.
3. Suppressed. Syn. Absence of breath sound.	Suppressed, etc.	Fehlendes Athemgeräusch.	Respiration supprimée.
4. Prolonged expiration. General or local.	Prolonged expiration. High or low in pitch.	Verlängertes Exspirium.	Expiration prolongée.
5. Interrupted inspiration. Syn. Jerking, wavy, cog-wheeled.	Interrupted respiration, etc.	Saccadirtes Athemgeräusch.	Respiration saccadée.
6. Tubular. Syn. Bronchial. High-pitched blowing.	Tubular. Bronchial, etc.	Bronchiales Athemgeräusch, (*a*) stark, (*b*) tief.	Souffle bronchique, (*a*) superficiel, (*b*) profond, (*c*) doux, (*d*) fort.
7. Vesiculo-tubular. Syn. Broncho-vesicular. Harsh, coarse, subtubular.	Broncho-vesicular. Syn. Vesiculo-tubular.	Unbestimmtes Athemgeräusch.	Respiration rude, broncho-vésiculaire.
8. Amphoric.	Amphoric.	Amphorisches Athemgeräusch.	Souffle cavitaire amphorique avec écho musical ou métallique.
9. Cavernous.	Cavernous.	(Not included.)	Souffle cavitaire simple ou sans écho musical.

Second Group. Adventitious Sounds.

1. Rhonchi. Dry musical sounds. (*a*) Sonorous, (*b*) Sibilant.	Rhonchi or dry bronchial râles. (*a*) Sonorous, (*b*) Sibilant.	Rhonchi. Trockene Rasselgeräusche. (*a*) sonor (schnurrend), (*b*) sibilans (pfeifend).	Ronchus. Râles secs. (*a*) Ronflants, (*b*) Sibilants.
2. Stridor.	Stridor.	Stridor. Stenosengeräusch.	Sifflement laryngé. Bruit de cornage. (*a*) Trachéal, (*b*) Bronchique.
3. Râles. Syn. Bubbling râles, etc. (*a*) Medium, (*b*) Large. High or low in pitch.	Moist or bubbling râles. (*a*) Large, (*b*) Medium, (*c*) Small. High or low in pitch.	Feuchte Rasselgeräusche. (*a*) grossblasige, (*b*) mittel grossblasige, (*c*) kleinblasige.	Râles humides. (*a*) Gros, (*b*) Moyens, (*c*) Fins. (*a*) A timbre bronchique, (*b*) Sans timbre ou simple.
4. Gurgling.	Gurgling.	Höhlenrasseln.	Gargouillement.
5. Clicking.	Clicking.	(Not included.)	Craquements. (*a*) Secs, (*b*) humides.
6. Crepitation. Syn. Crepitant râle.	Crepitant râle or crepitation.	Knisternde Rasselgeräusche, Knisterrasseln.	Râles crépitants.
7. Metallic tinkling.	Metallic tinkling.	Metallisches Rasselgeräusch, Metallklang.	Tintement métallique.
8. Splash.	Splash.	Succusionsgeräusch.	Succussion Hippocratique.
9. Friction. (*a*) Dry, (*b*) Moist.	Friction.	Reibegeräusch.	Frottement.

Third Group. Varieties of Voice Sounds.

1. Increase of vocal resonance.	Increase of vocal resonance.	(Not included.)	Voix exagérée.
2. Diminution or absence of vocal resonance.	Diminution or absence of vocal resonance.	Abschwächung und Fehlender Stimme.	Voix diminuée.
3. Bronchophony.	Bronchophony.	Bronchophonie.	Bronchophonie.
4. Pectoriloquy.	Pectoriloquy.	Pectoriloquie.	Pectoriloquie.
5. Ægophony.	Ægophony.	Ægophonie.	Egophonie.

The lists are arranged in the order of their reception.

the above-mentioned states is inconstant, their increase in leukæmia is a predominating symptom of this disease. Their size is, as a rule, much changed. The red disks may be of normal proportions even in vigorous development of the disease; and the reduction of their number does not necessarily reach the extreme degrees of the three diseases spoken of above, even when the disease has lasted a year.

PROF. TOMMASI-CRUDELI, of Rome, followed with a discourse, illustrated by drawings and microscopic preparations, on the subject of *Malaria*, dwelling upon the bacillus malariæ and more especially upon its influence in dissolving and disintegrating the protoplasm of the blood corpuscles, liberating the hæmoglobin to be deposited in the brain and elsewhere. Though the paper was interesting, it contained nothing especially new to those familiar with the works of Cuboni and Marchiafava.

The Section now adjourned to hear Pasteur on the subject of *Microbes Pathogènes et Vaccins*, in an address which contained no contributions to his work with which your readers are not already thoroughly familiar.

Pretty much the whole of the second day was taken up with *Tuberculosis*. The honor of introducing this subject was entrusted to PROF. EWALD, the accomplished editor of the *Berliner klinische Wochenschrift*.

Prof. Ewald took as his title *The Etiology, Diagnosis, Prognosis, and Treatment of Tuberculosis in Reference to Recent Researches in Pathological Anatomy and Experimental Pathology*, and in his paper which was really too long for such an occasion, covered the whole vast field thus announced. He commenced with the statement that the bacillus, which should only be called after its discoverer, the bacillus Kochii, was the sole cause of tuberculosis, and whoever would now deny this fact would place himself out of the limits of discussion. Scrofula, lupus, perlsucht, were only other forms of the same disease, and though clinically distinct had the same pathogeny. The question of predisposition and heredity was also exhaustively treated, but nothing was expounded different from accepted views. It was not true that the number of bacilli in the sputum afforded always a fair prognosis of tuberculosis, as the number present may be a matter of accident. In prophylaxis stress was laid upon the destruction of the products of the disease as well as upon the rejection of the milk and flesh affected with the perlsucht. There was nothing new in the way of treatment, as, indeed, there could not be without the speedy knowledge of it throughout the world.

After Ewald, came PROF. JACCOUD, of Paris, with a paper on the *Treatment of Tuberculosis*. It was quite a treat to hear Jaccoud. His articulation is clear and distinct, his voice penetrating and finely modulated, his manner animated, it would be more fair to say vivacious. Jaccoud made what the country students with us would call a ringing speech, and I doubt if the halls of the sleepy old University (I mean no detraction to the splendid scholars of this land) ever before resounded to the echoes of such eloquence. I have myself heard the best speakers in all lands, but I have never listened to such a declamation as this before, *ex cathedra medicale*. His peroration received an ovation of applause. It was curious to observe the excitement to which this staid, I had almost said phlegmatic, assembly was stirred under the stimulus of such an earnest appeal.

But in glancing over the hall it was easy to see that the interest on the part of some of the members was rather psychological than real, evincing a surprise rather than a pleasure at witnessing such a phenomenon in a hall of science. For the whole tenor of the speech was to the effect that while the discovery of the bacillus was a brilliant accomplishment, it had contributed nothing to the cure of the disease. The speech closed with a glowing tribute to the genius of Pasteur, who was present at the time, and indicated that studies pursued in the direction which he had pointed out would yield most practical results.

The discussion upon this subject was postponed until all the papers upon it had been read.

DR. GRANCHER, of Paris, now took the stand to read his paper on the *Diagnosis of Pulmonary Tuberculosis in the Early Stage*. He stated that pulmonary tuberculosis is always very difficult to diagnosticate in the early stages. The sources of medical diagnosis are, however, numerous, and have been recently enriched by the discovery of the tubercle bacilli in the sputa. In pulmonary tuberculosis of pneumonic form, when softening is very rapid, the bacilli may be found when the diagnosis rests on the physical signs and is yet doubtful. The same is true when pulmonary tuberculosis begins with hæmoptysis, or is concealed under the symptoms of diffuse bronchitis, with or without pulmonary emphysema. The presence of the tubercle bacilli is, then, the best of all signs.

But when the tubercles develop silently, and softening is very slow—which is most commonly the case—when the patient begins to cough and expectorate only after the disease has lasted for some time, the bacilli only appear in the pus of the sputa when their presence is superfluous for the diagnosis. The bacilli, when present, may be very rare and escape notice in a microscopical examination, but they are present in sufficient numbers to produce inoculation in guinea-pigs. Hence we have a method of diagnosis founded on the positive or negative results of inoculation. This method, however, requires some time (one or two months, and more if the results of the first inoculation are doubtful, and control-experiments are necessary); even in this there may be causes of error, as it is necessary, for the success of an inoculation, to have at least one bacillus in the inoculating material, and in these cases the diagnosis should be made before the bacilli can be found. But the physical signs are sufficient for a probable diagnosis at first, and later for a certain diagnosis.

Grancher has, in several cases, followed the evolution of the physical signs from the very beginning of the disease to the period of softening. Commencing with an alteration in the softness of the inspiratory murmur, and with a lowering of its tone, it is followed, even after a long stationary period, by prolonged expiration, and then, later, by bronchophony, diminished resonance, and expectoration. This process may last for three or four years or more. The progressive decrease in strength, emaciation, the cough, sputa, and other symptoms run a parallel course with the physical signs.

At what time can the diagnosis be made? Should we wait until percussion and palpation give positive results? Or can we, under certain circumstances, diagnosticate the presence of tubercles by the single alterations in the respiratory murmur? If the certainty of the diagnosis increases proportionally with the physical signs, the gravity of the disease also increases; for the slight dulness and bronchophony correspond to the accumulation of tubercles, or, in other words, to the age of the softening. Every variety of anomalous respiration (the interrupted, feeble, rude) may be indicative of commencing tuberculization. But in Grancher's opinion, rude respiration with lowered tone of the *inspiratory* murmur is the earliest and best of the physical signs at the commencement of pulmonary tuberculosis. This respiratory anomaly is, in his opinion, sufficient, when it is clear, localized at the apex of the lung, and when the *terrain* is suspicious (rebellious chloro-anæmia, scrofula, heredity, etc.), to give a probable diagnosis.

This alteration of the subclavicular murmur is shown, at the commencement of the disease, more often on the left side than on the right, which confirms the opinion

of those who think that, as a rule, tuberculosis of slow development commences on the left side; and diminishes the value of this symptom for those who think that the normal vesicular murmur is stronger in the left subclavicular region than the right. Grancher does not believe that there is any constant physiological difference in this respect on the two sides, but a transient or slight influence, a fugitive congestion at the time of the menopause for example, may alter the murmur on one side or the other. One should not, then, hasten to make a diagnosis of tuberculosis on the first discovery of rude inspiration, but this sign should lead to suspicion when it persists, and when rational symptoms are found on suspected *terrain*. Under these circumstances a probable diagnosis should be made, and the physician should at once begin treatment.

DR. QUINLAN, of Dublin, followed next with a paper on *The Use of Mullein in the Treatment of Tuberculosis*, for which he claims such wonderful results, as to have attracted to his hospital great crowds of patients. Dr. Quinlan passed around the house a gigantic specimen of the mullein over six feet in height, and distributed among the members several boxes of cigarettes made of its leaves. The principal points of his paper were as follows:

The Library of the Royal Irish Academy in Dublin contains a large number of manuscripts in the Celtic language, and treating upon medical subjects. Constant mention is made of the "cuineal mhuire" as a remedy in pulmonary diseases, and this plant has the most extraordinary reputation in the Celtic portions of the United Kingdom, and especially in Ireland, as a palliative and even curative remedy in cases of pulmonary consumption. In Ireland, although unrecognized by the medical profession, it has been for centuries given upon an immense scale in obedience to a steady demand on the part of phthisical sufferers; and during the last two years he undertook a scientific investigation as to its alleged powers, the highly satisfactory result of which he submitted to the Congress.

This plant is known to botanists as the Verbascum thapsus, and belongs to the natural order of Scrofulariaceæ. Its English name is the Great Mullein; in France it is known as Molène Bouillon Blanc, and in Germany as Kleinblumiges Wollkraut. The mode of using it is to place ʒvij of the dry leaves, or, much better, ʒiij of the fresh, in a pint of new milk, to boil and allow to stand for ten minutes, then to filter and add a little sugar. This whole mixture is to be drunk morning and evening.

A large number of cases of pulmonary consumption have been treated in St. Vincent's Hospital, Dublin, exclusively upon mullein. These cases were all carefully tabulated and the patients weighed once a week, great care being taken to insure conformity of conditions in this respect. The results arrived at are as follows:

1. In the early and pretubercular cases of the disease Mullein is weight-increasing and curative to a much greater extent than koumiss or cod-liver oil.

2. In advanced cases it does not cure, but gives greater relief to phthisical cough and prevents or checks phthisical diarrhœa.

3. It has no effect upon the colliquative perspirations of phthisis.

4. In phthisical coughs and in spasmodic coughs generally great relief can be obtained by smoking mullein leaves in the same manner as tobacco.

This can be effected either in an ordinary pipe or by means of cigarettes. On the dried mullein leaf powder a very weak solution of potassium nitrate is sprinkled and flavored with oil of cascarilla. These cigarettes are rolled in paper in the ordinary way, and are very pleasant to smoke. Mullein has been tried in watery infusion, but is disagreeable. The same remark applies to the extract or succus.

It may be said that the weight-increasing effects were due to the milk; but experience shows that this was not so. It is greatly liked by the phthisical sufferers.

DR. R. SHINGLETON SMITH, of Bristol, came next in order with a paper on *The use of Iodoform in the Treatment of Phthisis*.

After a short review of the history of iodoform as a drug for internal administration, the author gave an analysis of the results of treatment in forty-six cases arranged in tables to show the variation in weight before and after treatment: in twenty-nine out of the forty-six cases, there was an absolute gain in body-weight, amounting in one case to thirty-two pounds, and in another to thirty-three pounds. Other indications of improvement were fall of temperature, diminution of cough and expectoration, cessation of night-sweats, improved appetite. The drug was given in doses varying from one to six grains five times daily, and was continued for several months. Toxic symptoms of a mild character had been observed in some of the cases. The paper concluded with a reference to the local use of iodoform in tuberculous disease of the larynx.

The afternoon was devoted to the discussion of the papers read.

Remarks were made first by DR. GUTTMANN, of Berlin, who made the very good point that they were as familiar in Berlin as in Paris with the fact that the discovery of the bacillus tuberculosis did not cure consumption, and that they were acquainted with another fact, to wit—the reason why no remedy has been found to reach the disease, viz., because the bacillus tuberculosis, as the result of a great many experiments, proved to be more resistant to destructive agents than the tissues in which it was found.

DR. PIBBRAM, of Prague, paid a glowing tribute to Koch, and remarked that the discovery was as yet of too recent date to furnish practical results.

DR. CROCQ, of Brussels, followed in a very curious speech, discrediting all previous theories and facts, and declaring one of his own. The remarks were delivered in very voluble French, and as it is quite difficult to follow idiosyncrasies in a foreign tongue, I failed to make out exactly the author's views.

The remarks of the last speaker extended over so much time that the discussion was called to a close, with permission to DR. EWALD to make a short response, which was delivered in very good French, and chiefly expressed the satisfaction of the speaker at the unanimity of opinion regarding the fact of the existence and the causative relation of the bacillus of Koch. He could not respond to Dr. Crocq, he said, as this gentleman was not in accord with any of the recent views.

DR. BRANDES, of Copenhagen, now presented a case of *Myxœdema*, and made some remarks upon the pathology of this affection.

SIR WILLIAM GULL, of London, in the discussion which followed, was inclined to consider the case as one of simple cretinism in the adult. This affection, he said, is usually believed to be a disease of childhood only, but, in the speaker's opinion, existed or developed also in adult life.

DR. MAHOMED, of London, did not regard myxœdema as a disease of the thyroid gland alone, or as an affection of any one part of the body. It was the expression of a perverted nutrition, the result of affection of the nervous system from many different causes. He instanced two cases of recovery from the disease, and spoke of post-mortem examinations in which capsulitis of the liver was found, but no increase of mucin in the tissue affected.

The afternoon session closed with a paper by DR. JOSEPH EWART, of London, on *The Treatment of Chronic Diarrhœa and Dysentery in Persons returned from Tropical to Temperate Climates, by Milk Diet.*

SURGICAL SECTION.

(*From our Surgical Correspondent,*)

NORTH SEA, S. S. RONA, August 16, 1884.

On Monday the 12th, PROF. PLUM, of Copenhagen, took the Chair, and in a few feeling words spoke of the recent sad death of Dr. Holmer, who was to have been President of the Section. He called on Sir Henry Acland, of Oxford, to say a few words regarding him.

SIR HENRY ACLAND spoke of when he first made Holmer's acquaintance at a time when, as a stranger to Copenhagen, he needed the aid of a medical man. He spoke of Holmer's kindness, gentleness, and skill, and said that it was with some difficulty that he came to Copenhagen after he heard that Dr. Holmer was dead. He expressed, in the name of the strangers present, the deep regret that they felt for the loss of so distinguished a man, and he conveyed to the Scandinavian members of the Section the sympathy that was felt for them by their guests.

After the election of Vice-Presidents and Secretaries, Prof. Plum asked Prof. Volkmann to take the Chair.

PROF. ESMARCH, of Kiel, then read a communication on *Extirpation of the Cancerous Rectum.* After speaking generally of the pathology of cancer, the writer pointed out the danger of delay in operating on cancer of the rectum and the necessity for complete removal. Hemorrhage was checked by the use of the double ligature, all bands being tied before division. Sepsis was avoided by packing with sublimate gauze. Drainage and the escape of feces were obtained by the introduction of a large tube. The peritoneum was often opened when the tumor was situated high up. The mortality of the operation is about twenty per cent. The anus and sphincter were left, no stitches were used, and there was no necessity for excision of the coccyx to give space.

MR. BRYANT, of London, then read a communication on *Lumbar Colotomy as a Curative and Remedial Operation in Syphilitic, Simple, and Cancerous Ulceration of the Rectum and Colon, with an Improved Method of Performing the Operation.*

This paper is based upon Mr. Bryant's personal experience of eighty-two cases. It includes an analysis of the cases, and affords evidence which the author deems conclusive in support of the following propositions:

1. That in all cases of cancerous stricture of the rectum or colon, including the annular—which are not amenable to lumbar *colectomy* or anal excision—right or left lumbar colotomy is strongly to be advocated with the well-grounded hope of relieving suffering, retarding the progress of the disease, and of prolonging life even for five or six years.

2. That lumber colotomy is valuable as a *curative* operation in syphilitic and simple ulcerations of the bowel which resist other treatment, including cases of recto-vesical fistula; and that it is remedial in examples of volvulus of the sigmoid flexure, as well as of obstructions caused by tumors.

3. That to secure these advantages, it is necessary for the operation to be performed before the pernicious effects of obstruction occur.

The details of the improved method of performing the operation were also given.

Mr. Bryant then gave the following analysis of the whole number of eighty-two cases of colotomy: 60 were performed for cancerous stricture; 19 were performed for stricture and ulceration of the rectum not cancerous; 1 was performed for volvulus of the sigmoid flexure of the colon; 2 for obstruction due to pelvic tumors.

Side operated upon: Left lumbar colotomy was performed in 77, and right lumbar colotomy in 5 of these cases, all of the five being cancerous. Right lumbar colotomy was called for in 1 out of 12 cases of cancerous stricture.

Duration of life after the operation: 26, or 43 per cent. of the cancerous, and 6, or 31.5 per cent. of the non-cancerous cases, with one of the cases operated upon for obstruction, or 40 per cent. of the whole number of 82 cases operated upon, died within the month.

34, or 56 per cent., of the cancerous, and 13, or 68.5 per cent. of the non-cancerous cases, with the case of volvulus and one of the cases of obstruction, or 60 per cent. of the whole number of cases operated upon, received more or less fully the benefit of the operation.

Of the forty-nine successful cases:

16	cases,	9	cancerous, and	7	non-cancerous,	died within 6 months.
8	"	7	"	1	"	lived from 6 to 12 months.
12	"	9	"	3	"	lived from 1 to 5½ years.
5	"	1	"	4	"	were alive from 1½ to 14 years after operation.
8	"	8	"			had left the hospital convalescent.
49		34		15		

Sex.

Of the 60 cancerous cases:	40	were in males,	20 in females.
" 19 non-cancerous:	10	"	9 "
1 case of volvulus:	1	was in male.	
2 cases of obstruction:	1	"	1 in female.
Of the 82 cases:	52	were in males,	30 in females.

Cancerous stricture is more frequent in males. Non-cancerous stricture is found equally in both sexes.

Age.

The average age of the cancerous case,
When fatal was 53: in male subjects 54, in female 51.
" successful 44 " 46 " 41.

The average age of the successful being about 10 years less than that of the fatal cases.

No abnormality as to the position of the colon was met with in any of the 82 cases.

PROF. VERNEUIL, of Paris, opened the discussion. He began by saying that he performed his first case of excision of the rectum fifteen years ago, his first colotomy thirty years ago. He believed complete removal to be difficult, and recurrence after operation frequent, and his patients objected to colotomy. He thought all the painful symptoms were most easily relieved by making an artificial channel from the tip of the coccyx, with the thermo-cautery, to a point in the rectum above the stricture. He then passed the chain of an écraseur along this channel and brought it out at the anus, by which means he was enabled to divide the strictured part and sphincter bloodlessly and without danger to life.

MR. SAMPSON GAMGEE, of Birmingham, thought inguinal colotomy the preferable operation, but each case must be judged of by itself. No general rule will suit all cases.

MR. MARSHALL, of London, spoke of the value of the method of relief recommended by Prof. Verneuil.

PROF. VOLKMANN, of Halle, thought excision safer than colotomy. He spoke of the slow growth of cancer of the rectum, and the long time that elapsed before the glands became affected. He believed the comfort to be greater after excision than after colotomy. He never operates in cases in which he cannot reach the upper end of the disease. He gave chloroform and examined by the bimanual method before operating. No attempt was made to stitch the upper to the lower end.

MR. HENRY MORRIS, of London, spoke of the value of lumbar colotomy, and presented statistics of his practice.

PROF. KUSTER, of Berlin, spoke of the value of iodoform as a dressing after excision of the rectum.

PROF. PAQUET, of Lille, showed an example of *Hypertrophy of the Upper Jaw Removed by Excision and the Upper End of the Femur Removed in a Case of Amputation of the Hip-joint with the Thermo-cautery.*

MR. REGINALD HARRISON, of Liverpool, then read his paper on *The Treatment of Certain Cases of Prostatic Obstruction by Section of the Gland.*

This class includes cases in which there is unusual difficulty in introducing the catheter, in which the withdrawal of the urine is followed by no sense of relief, and in which the bladder, by the constant presence within it of pus and tenacious mucus, is converted into little else than a chronic abscess through which urine percolates. These, as well as some other forms of prostatic disease which might be included, are practically unrelievable by the catheter, and speedily terminate in painful death. He had been impressed with the advantage that followed the judicious employment of suitable bougies as dilators in cases in which the prostate threatened to obstruct micturition.

Influenced by observations of this kind, he was led to attach considerable importance to the treatment immediately following section of the obstructing portion of the enlarged gland with the view of rendering the latter more permanent than had hitherto been attempted.

The operation consists in opening the membranous urethra from the perineum on a guide, and introducing the finger within the prostatic urethra. The obstructing portion of the gland is then divided in the median line, partly by incision with a straight probe-pointed knife, and partly by divulsion with the finger or large-sized bougie until the access to the bladder is felt to be free. In doing this operation it is not desirable to make an opening larger than will admit the index finger from the perineum into the bladder, such an opening is completely filled up by the drainage-tube that is subsequently used, and consequently but little risk of hemorrhage need be entertained.

The drainage-tubes Mr. Harrison is in the habit of employing after section of the prostate has been effected are gum-elastic, with a special provision for the more thorough drainage of the bladder than has hitherto been attempted. This consists in the employment of a double tube. He attaches very considerable importance to the prolonged use of the drainage apparatus, as his object is to render the section of the prostate not a temporary one, as after a lithotomy where no such provision is made, but permanent. Hence he is in the habit of retaining these tubes for six, eight, ten, or twelve weeks. If after such periods, on removing the tube, he finds that a catheter can be made to enter the bladder easily along the natural route, or if, as it sometimes happens, urine forces its way in spite of the perineal tube along the natural passage, he regards these as indications that the object in view in the retention of the drainage-tube has been obtained. The regular use of the bougie is continued until the perineal wound has soundly healed, a process which usually takes place rapidly, and leaves but little mark. As a precautionary measure, patients are enjoined to continue to use the bougie occasionally.

It will be observed that section of the bar is preceded in all instances by a careful digital exploration of the prostatic urethra, with the view of directly determining the nature of the obstruction and the direction of the incision to remove it.

In some instances, in which stone in the bladder has been secondary to the formation of a prostatic bar and the incomplete emptying of the bladder, lithotomy has been selected as affording opportunity, not only for the removal of the stone, but the bar which led to its formation. In a case of recurring stone, this operation has been followed by the continued excretion of urine of an acid reaction, when after previous lithotrities the urine was invariably alkaline.

In offering an explanation of the results obtained, Mr. Harrison thinks we have it, not only in the means which are adopted to render the section of the prostate permanent, but further, he believes something is due to the introduction into the prostate of no inconsiderable quantity of shrinking or cicatricial tissue.

PROF. VOLKMANN spoke of the value of a perineal median opening with drainage, without dividing the prostate gland.

On Tuesday, at 9.30 A.M., PROFESSOR SAYRE, of New York, gave a demonstration to a large audience of continental surgeons on his method of applying *The Plaster Jacket in Cases of Pott's Disease of the Spine and in Lateral Curvature.* This demonstration was completed on Friday at the same hour; a case in which he had

applied the jacket on Tuesday being then brought forward with the jacket in a finished condition.

At 10 A.M. MR. THOS. BRYANT, of London, took the Chair, and PROFESSOR OLLIER read a paper on *Excision and Arthrotomy in Tuberculous Joint Disease.* He recommended in those cases free removal of all diseased tissue, care being taken, by cauterization of the joint, to prevent tension. The sharp spoon and cautery were freely used to remove and destroy all diseased tissue.

DR. LOWENSTEIN, of Hamburg, showed a case in which he had *Excised an Ankle-joint* after the method of Mikulicz. The disease was completely removed, and the result closely resembled an aggravated case of talipes equinus.

PROFESSOR SKLIFFOSOWSKI, of Moscow, related his experience of such cases, and recommended a similar treatment.

DR. MACEWEN, of Glasgow, read a paper entitled *Osteotomy for Genu Valgum.* He brought forwards a large mass of statistics showing that the supracondyloid operation associated with his name had obtained the approval of a large majority of the profession, and that the operations of Ogston, Chiene, and Schede had been used by comparatively few British surgeons.

PROFESSOR OGSTON, of Aberdeen, said that he would now use MacEwen's method in preference to his own; and PROFESSOR CHIENE. of Edinburgh, promised to give it a fair trial. DR. SCHEDE said that in some cases he believed division of the tibia to be necessary.

DR. ROBIN, of Lyons, exhibited an ingenious *Instrument for Fracturing the Femur above the Condyles.* In the specimens he showed that the line of fracture was at a higher level than where the bone is divided by MacEwen.

MR. W. ADAMS, of London, demonstrated, by a series of photographs taken from cases of *Dupuytren's Finger-contraction*; the method which he preferred, by subcutaneous division of the fascia at many points, in the treatment of such cases.

In the afternoon a discussion took place on Professor Ollier's paper. This discussion was opened by Professor Chiene, of Edinburgh, and Professors Volkmann and Trélat took part in it. The opinion of Volkmann and Trélat was that the diseases of bone near joints were almost always tubercular, and that free removal of the diseased tissues was necessary in order to prevent generalization of the disease throughout the body.

DR. HOWE, of New York, showed a *Calculus* over eight ounces in weight which he had *Removed by the Suprapubic Operation* from a boy. The boy recovered satisfactorily. The peritoneum was wounded.

On Thursday, August 14th, PROFESSOR TRÉLAT, of Paris, took the Chair. It was hoped that Professor Lister would open the discussion on antiseptic surgery; much regret was expressed at his absence, and President Plum spoke of the honor that they, as surgeons, owed to Professor Lister.

PROFESSOR ESMARCH read a paper on the *Permanent Antiseptic Dressing.* He spoke of Lister as the master and teacher of them all. He desired: 1. Avoidance of suppuration. 2. Non-disturbance of the wound. 3. Exact hæmostasis. 4. Avoidance of cavities. 5. Drainage by leaving an opening between the stitches. Artificial ischæmia, catgut ligature, washing during operation with solution of salt in distilled water, afterwards with corrosive sublimate lotion. After applying deep stitches he applied peat pillows, no mackintosh, and lastly soft bandages, fixing the parts with glass bandage. This dressing was kept on for ten days or a fortnight.

PROFESSOR MOSETIG V. MOORHOF, of Vienna, read a paper on the *Iodoform Treatment of Wounds.* He used iodoform and nothing else, and simple water as a wash.

DR. SCHEDE, of Hamburg read his paper on *The Sublimate Treatment of Wounds.* He used no other antiseptic, and gave statistics of his results. He had had no poisoning since using 1 in 2000 to disinfect and 1 in 5000 as a lotion. He used glass wool instead of protective-sublimate moss as a dressing.

PROFESSOR MIKULICZ, of Krakow, used iodoform in the cavities of wounds lined with much membrane.

In the discussion which followed, Prof. Neudorfer laid special stress on dryness of the wound. Prof. Buchanan, of Glasgow, stated that he used carbolic acid, and laid much importance on free drainage. Mr. Schelkly, from America, at first used Listerism, but now used a combination of salicylic acid with iodoform or corrosive sublimate lotion with boric lint. Prof. Kœberlé, of Strasbourg, also spoke of the importance of preparing patients for operation, and said that no special antiseptic should be extolled at the expense of others. Prof. Trélat also spoke.

The general impression gained from this discussion was that each surgeon seemed to lay stress on his own method, and that with it he got good results.

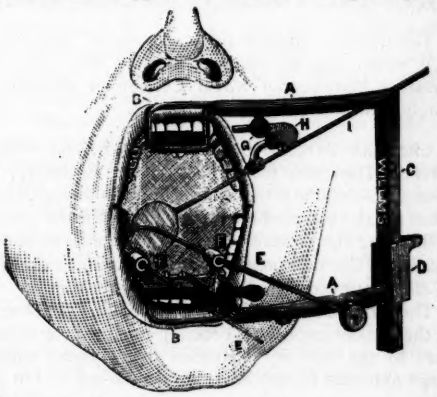
NEW INVENTIONS.

A NEW GAG, WITH TONGUE-DEPRESSOR AND MIRROR-ATTACHMENT.

BY RUSSELL MURDOCH, M.D.,
OF BALTIMORE, MD.

THE gag is a counterpart of an eye-speculum described by me in the *Transactions* of the American Ophthalmological Society for 1883.

It has two blades (A A) with teeth-rests (B B). At the distal end of the upper blade there is, at right angles to



it, a rectangular bar (C). Similarly situated on the lower blade, is a sleeve (D) with square lumen. This sleeve fits closely over, and slides on the bar, and to effect this there is a convenient handle projecting from the side of the sleeve. The teeth of the patient lock the

instrument at any desired point, and consequently no set-screw or catch is needed.

The tongue-depressor (E) is made of No. 12 Stubbs's gauge wire. It is shaped like a long-armed capital letter U. A retaining button is screwed on one arm. When attached to the gag, the arms are encircled and slide through the two oscillating sleeves (F F), which ride upon the lower mouth-rest. These, together, maintain the horizontal plane of the depressor. A cog-wheel, attached to the right-hand sleeve, allows the surgeon to depress its point, but any return movement is prevented by a spring pawl.

The laryngoscopic attachment (H) consists of two elbows united by a universal joint. One has a sleeve which encircles the stem of a mirror (I), and through which it slides and rotates. The other elbow has a short rectangular arm, bevelled at its free end, and this fits in the socket of either of the raised buttons (G G) on the blades of the gag. The upper button supports the mirror in laryngoscopic, and the lower in rhinoscopic observations.

The chief claims of the gag for professional notice are the automatic character of the fixation by the teeth, and its greater promptness of removal from the mouth than any in use.

An attached tongue-depressor to a gag will, it is thought, commend itself as worthy of frequent trial in many throat operations. A suspended mirror, and also the addition of a palate retractor, suspended by an attachment similar to that of the laryngoscopic mirror to the other button on the gag, will give two free hands and a visible cavity while operating on a post-nasal growth.

NOTE.—These instruments have been made by the well-known firm of Wilms & Co., of Baltimore. They can be obtained of them singly or as a set.

NEWS ITEMS.

THE NEW HYGIENIC INSTITUTE IN BERLIN.—Dr. Robert Koch has been appointed Director of the new Hygienic Institute attached to the University of Berlin.

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.—It is stated that as residuary legatee of the late Sir Erasmus Wilson, the Royal College of Surgeons of England will receive about £180,000.

CHOLERA PRECAUTIONS IN ENGLAND.—Sir William Vernon Harcourt, the British Home Secretary, has issued a circular to the officials of English prisons, urging them to take extraordinary precautions for the purpose of keeping the prisoners in their charge clean and the prisons in the best possible sanitary condition, in view of the continued prevalence of cholera.

The Home Secretary has also issued an official notice to the factory inspectors, ordering them to give especial care to the sanitary condition of all places wherein large numbers of operatives are employed and to give every necessary sanitary instruction to the factory hands.

This action on the part of the Cabinet is accepted as an indication that the government are more alarmed now than they have been at any time since the outbreak of cholera in France, and that they possess information of the actual introduction into England of the seeds of the plague and entertain fears of a probable outbreak of the scourge.

OBITUARY RECORD.—Died at Narragansett Pier, on Sunday, August 31st, RIGGIN BUCKLER, M.D., of Baltimore, aged fifty-three years. Dr. Buckler was born in Baltimore November 4, 1831; he graduated in the Arts at Harvard University in 1851, and received his degree of M.D. from the University of Maryland in 1853. He visited Europe and remained there four years in hospital service. On returning to this country in 1857, he settled in Baltimore in general practice, and soon achieved prominence in his profession. He twice held the place of Surgeon-General of the State of Maryland.

NOTES AND QUERIES.

PERMANGANATE OF POTASSIUM.

To the Editor of THE MEDICAL NEWS.

SIR: The *modus operandi* of permanganate as a deodorizer, that is, its immediate decomposition on contact with organic matter, is so frequently overlooked by prescribers as to seem to justify calling attention to this matter. For instance, in the last number of THE NEWS, page 184, an article appears, taken from a French journal, recommending that soles of cork, etc., be soaked in a solution of permanganate and dried, for use as pedal deodorizers. The permanganate would be decomposed at once on coming in contact with the organic material. The sprinkling of poultices with the solution is another mistake, for the same reason. Glycerine used in gargles, also, is equally destructive. Permanganate pills are now much in vogue for amenorrhœa; the salt can, with proper pharmaceutic skill, be put up in the pill form, an inorganic excipient being used, but the fact remains that it is decomposed on reaching the stomach, and any effect following the administration must be due to the manganese oxide.

Yours, T. D. REED, M.D.

MONTREAL, August 20, 1884.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM AUGUST 26 TO SEPTEMBER 1, 1884.

HEAD, JOHN F., *Colonel and Surgeon.*—Granted leave of absence for four months.—*S. O. 201, A. G. O.*, August 27, 1884.

WOODHULL, A. A., *Major and Surgeon.*—Detailed as member of Medical Examining Board, at U. S. Military Academy, West Point, N. Y., vice Capt. R. H. White, relieved. Upon adjournment of the Board, to return to his proper station.—*S. O. 201, C. S., A. G. O.*

BARTHOLF, J. H., *Captain and Assistant Surgeon.*—Relieved from duty in the Department of the Columbia, and to report in person to the Commanding General, Department of Texas, for assignment to duty.—*S. O. 199, A. G. O.*, August 25, 1884.

FINLEY, J. A., *Captain and Assistant Surgeon.*—The leave of absence granted him in S. O. 91, C. S., Department of Texas, extended two months.—*S. O. 198, A. G. O.*, August 23, 1884.

TAYLOR, M. E., *Captain and Assistant Surgeon.*—Granted leave of absence for four months, to take effect on arrival of a medical officer at Davids' Island, N. Y., to replace him.—*S. O. 200, A. G. O.*, August 26, 1884.

GIBSON, R. J., *First Lieutenant and Assistant Surgeon.*—Relieved from duty in Department of the Missouri, and to proceed to the Department of California for duty.—*S. O. 202, A. G. O.*, August 28, 1884.

DIETZ, WM. D., *First Lieutenant and Assistant Surgeon.*—Relieved from duty at the Military Academy, West Point, N. Y., and ordered to the Department of the Missouri for duty.—*S. O. 202, A. G. O.*, August 28, 1884.

APPOINTMENT.

MCCAW, WALTER D.—Appointed Assistant Surgeon, with rank of First Lieutenant, to date from August 20, 1884.

PROMOTION.

LIPPINCOTT, HENRY.—Promoted Major and Surgeon, to rank from August 17, 1884, vice Woodward, deceased.